Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00501

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Florence	T.	Safrit	January	7	2001	0630

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-01-2808	1☐ M 2☒ F	83 Yrs.					Sept. 12,1917	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Gambrills	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
901 Kendsha Court	21054	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Secretary	NASA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard M. Thornton	Mattie E. Berry

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jim Higgins (Son)	901 Kendsha Court, Gambrills, MD 21054

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Meadowridge Cemetery	01/11 2001	Elkridge, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael D. Kuttas	Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PERITONITIS	1 DAY
Due to (or as a consequence of):	b. PERFORATED VISCUS	1 DAY
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CHRONIC LYMPHOCYTIC LEUKEMIA	8 YEARS
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Peter R Graze MD	D16364	1/08/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER R GRAZE MD 900 BESTGATE RD 300 ANNAPOLIS MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 12 2001	▶ Jeanne M Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00502

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Catherine Smith

2. Date of Death (Month, Day, Year): January 8, 2001

3. Time of Death: 7:30AM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-14-7698

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 20, 1922

9. Birthplace (State or Foreign Country): Balto., MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Upper Falls

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11507 S. Chapman Road

10f. Zip Code: 21156

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Her own Home

17. Father's Name (First, Middle, Last): John J. Link

18. Mother's Name (First, Middle, Maiden Surname): Ruby McWillis

19a. Informant's Name/Relationship (Type, Print): Warren Smith (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11507 S. Chapman Rd Upper Falls, MD 21156

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory | Date: 1/11/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: E. F. Lassahn

22. Name and Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Road Kingsville, MD 21087

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Bronchitis — 30 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Sarraf MD.

29c. License number: 203307

29d. Date signed (Month, Day, Year): 1-8-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Haider Sarraf MD 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: [illegible] Sparks

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ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Smith, Frances

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00503

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN E. SIEMON, III
2. Date of Death (Month, Day, Year): JANUARY 8, 2001
3. Time of Death: 2:15 PM
4a. Facility Name (If not institution, give street and number): CRESCENT CITY NURSING CENTER
4b. City, Town, or Location of Death: HYATTSVILLE
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 220-42-1897
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 2, 1946
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6103 62nd Place
10f. Zip Code: 20737
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: DEPT. OF NAVY

17. Father's Name (First, Middle, Last): JOHN E. SIEMON, JR.
18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH THOMPSON

19a. Informant's Name/Relationship (Type, Print): Martha Siemon - sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3230 Spartan Rd. #69 Olney, Md. 20832

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Huntt Crematory | Date: Jan. 10, 2001
20c. Location - City or Town, State: Waldorf, Md.

21. Signature of Funeral Service Licensee: Michael L. Bigler
22. Name and Address of Facility: ROBERT E. EVANS FUNERAL HOME INC 16000 ANNAPOLIS RD., BOWIE, MD. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Respiratory arrest — 5 hrs.
Due to (or as a consequence of):
b. Cancer lung with metastasis. — 6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Peripheral Vascular disease.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D19609
29d. Date signed (Month, Day, Year): JANUARY 10, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RAMAN R. TULI, MD 3503 PERRY ST., MT. RAINIER, MD.

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00504

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Singleton
2. Date of Death Month Day Year: 01 - 06 - 2001
3. Time of Death: 7am
4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 080 14 0425
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 31, 1922
9. Birthplace *(State or Foreign Country)*: Turkey

Usual Residence of Decedent

10a. Stete: Florida
10b. County: Pinellas
10c. City, Town or Location: Palm Harbor
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 3162 Jademoor Circle
10f. Zip Code: 34685
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Personnel Assistant
16b. Kind of Business/Industry: U.S. Post Office

17. Father's Name *(First, Middle, Last)*: Hyman Levine
18. Mother's Name *(First, Middle, Maiden Surname)*: Sultana Levy

19a. Informant's Neme/Relationship *(Type, Print)*: Daughter Patricia Singleton Achimovic
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 12300 Chalford Lane Bowie Maryland 20715

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Flagler Memorial Park — Date: Jan. 10, 2001
20c. Location - City or Town, Stete: Miami Florida

21. Signature of Funerel Service Licensee: Robert E. Evans
22. Name end Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	Coronary artery disease	10 years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — b.		
Due to (or as e consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation
Congestive Heart Failure
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office buiiding, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Ramona Seidel MD
29c. License number: D0052944
29d. Date signed *(Month, Day, Year)*: 1/7/01

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): 600 Ridgely Ave Annapolis MD Ramona Seidel M.D.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrer's Signature: Jeanne G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00505

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Secco

2. Date of Death Month / Day / Year: January 9, 2001

3. Time of Death: 0600

4a. Facility Name *(If not institution, give street and number)*: 10912 Rock Coast Road

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 215-52-6375

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov/20/1947

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: MD.

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10912 Rock Coast Road

10f. Zip Code: 21044

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 6

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Special Education Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Ernest Frederick Schnaebele

18. Mother's Name *(First, Middle, Maiden Surname)*: Lois Elaine Peed

19a. Informant's Name/Relationship *(Type, Print)*: John Secco-husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10912 Rock Coast Road, Columbia, Maryland 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crestlawn Memorial Gardens

Date: 01/11/2001

20c. Location - City or Town, State: Marriottsville, Maryland

21. Signature of Funeral Service Licensee: Debra M Ross

22. Name and Address of Facility: Witzke Funeral Home of Columbia, 5555 Twin Knolls Road, Columbia, Maryland 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Ovarian Cancer — 2 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wm C Waterfield MD

29c. License number: D24356

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wm C WATERFIELD MD, St Agnes Cancer Center, 900 Caton Ave, Balt. Md 21229

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2001 JAN 12 AM 12:21

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #7 PER F.H. G791 1-19-01 WR.

Certificate of Death

Reg. No. 2001 00506

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
LUCIA	SACCA	JANUARY 8, 2001	10:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2421 EDWARDS MANOR DRIVE	FOREST HILL	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-46-5555	1☐ M 2☒ F	90 Yrs.			MAY 25, 1910	ITALY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	ROSEDALE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7708 PHILADELPHIA ROAD	21237	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ANTHONY PIRRUCCELLO	LIBERATA (VINCI)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SOPHIA SACCA	109A SUNSHINE COURT FOREST HILL, MD 21050

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HOLY REDEEMER CEMETERY	1/11/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CONGESTIVE HEART FAILURE	
	Due to (or as a consequence of):	
	b. COLON CANCER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c. DECUBITUS ULCERS	
	Due to (or as a consequence of):	
	d. CORONARY DISEASE	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) DAUGHTER'S

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD.	D45921	JANUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED F. MAHMOOD M.D. 4-B NORTH AVENUE SUITE 302 BEL AIR, MD 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 12 2001	[signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00507

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MATTHEW S. TASSYN
2. Date of Death (Month, Day, Year): January 8, 2001
3. Time of Death: 5:58 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-12-8137
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 18, 1911
9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1316 Fenwick Lane, #1003
10f. Zip Code: 20910
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): — College (1-4or 5+): 4 +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service worker
16b. Kind of Business/Industry: Self Employed

17. Father's Neme (First, Middle, Last): (Unknown) Tassyn
18. Mother's Name (First, Middle, Meiden Surname): Helen Holiday

19a. Informent's Neme/Reletionship (Type, Print): Leroy Holiday - cousin
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 3314 Trailway Park, SAn Antonio, Texas 78247

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Maryland National Memorial Park
Dete: 1-12-01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ Julia P. Marshall
22. Name end Address of Fecility: Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death):
a. Pneumonia — 1 day

Due to (or as a consequence of):
b. Myocardial Infarction — 1 day

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or es a consequence of):
c. Hypoglycemia

Due to (or es e consequence of):
d. Diabetes

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ Sharma MD
29c. License number: D 40804
29d. Dete signed (Month, Day, Year): 01/09/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): K. Sharma, M.D. 10620 Georgia Avenue #114, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 12 2001
32. Registrer's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0150-510

JOSEPH WELSH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00508

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Edmund Welsh
2. Date of Death Month / Day / Year: JANUARY 9, 2001
3. Time of Death: 3:24P.M.
4a. Facility Name *(If not institution, give street and number)*: 428 S.PAYSON STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-26-8685
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 21, 1929
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 428 S. Payson Street
10f. Zip Code: 21223
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: paper cutter
16b. Kind of Business/Industry: paper manufacturing

17. Father's Name *(First, Middle, Last)*: Edmund W. Welsh
18. Mother's Name *(First, Middle, Meiden Surname)*: Delia Agnes Donahue

19a. Informant's Name/Relationship *(Type, Print)*: Leo I. Welsh - Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1311 Appleby Avenue, Baltimore, Maryland 21209

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory, Inc.
Date: 1/14/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ann Y. Zink
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? INSPECTION 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* SCENE
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore M. King MD
29c. Licanse number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JANUARY 10, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: Deanna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

WCF 10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00509

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christopher Joseph Wall
2. Date of Death: Month January Day 8 Year 2001
3. Time of Death: 11:10 am
4a. Facility Name (If not institution, give street and number): 470 Rita Drive
4b. City, Town, or Location of Death: Odenton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 077-24-1550
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 14, 1929
9. Birthplace (State or Foreign Country): New York

Usuet Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Odenton
10d. Inside City Limits: 1 ☐ Yes 2 XX No
10e. Street and Number: 470 Rita Drive
10f. Zip Code: 21113
10g. Citizen of What Country?: USA

11. Maritel Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Yeer or Dates: Korean
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Reca - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Communication Frequency Manager
16b. Kind of Business/Industry: Federal Government

17. Fether's Neme (First, Middle, Last): William Michael Wall
18. Mother's Name (First, Middle, Meiden Surneme): Nora Ruane

19e. Informant's Name/Reletionship (Type, Print): Patricia Ann Wall (Wife)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 470 Rita Drive, Odenton, MD 21113

20e. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Ptece of Disposition (Neme of cemetery, cremetory or other piece): Maryland Veterans Cem.
Date: 01/11 2001
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Patrick J Arndt
22. Neme and Address of Fecility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset end Death

Immediete Cause (Finet disease or condition resulting in death): a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or as e consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE COR PULMONALE

23b. Did tobacco uas contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were eutopsy tindings aveilable prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)

27. Menner of Death: 1 ☐ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Raymundo Caparros M.D.
29c. License number: D0041284
29d. Dete signed (Month, Day, Year): 1/9/01

30. Neme snd address of person who completed cause of death (Item 23a) (Type, Print): RAYMUNDO CAPARROS - 1600 CAIN HWY. GLEN BURNIE, 21061

State Registrar

31. Dete filed (Month, Dey, Year): JAN 12 2001
32. Registrar's Signeture: Lenore G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 005110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank E. Wright, Jr.

2. Date of Death Month: January Day: 7 Year: 2001

3. Time of Death: 0030

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-38-2753

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 2, 1930

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1297 Swan Drive

10f. Zip Code: 21401

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cable Splicer

16b. Kind of Business/Industry: Electrical

17. Father's Name (First, Middle, Last): Frank E. Wright, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Hunt

19e. Informent's Neme/Relationship (Type, Print): Audrey Wright (Wife)

19b. Meiling Address (Street and Number or Rurei Route Number, City or Town, State, Zip Code): 1297 Swan Drive, Annapolis, MD 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Maryland Veterans Cem.

Date: 1/11 2001

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: ▶ Michael P. Kuttab

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

e. sepsis

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Lung Cancer

Due to (or as a consequence of):

c. Chronic obstructive airway disease

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, In my opinion, deeth occurred et the time, dete end placa, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ MZMI MD

29c. License number: D0051437

29d. Date signed (Month, Day, Year): 01/8/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DARCY IBITOYE AAMC ANNAPOLIS MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00511

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDNA I. WHITT
2. Date of Death (Month, Day, Year): January 8 2001
3. Time of Death: 15:07
4e. Facility Name *(If not institution, give street and number)*: UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 235-52-8764
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 8, 1912
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 528 Beach Drive
10f. Zip Code: 21220
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent ot Hispanic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8th grade; College (1-4or 5+): N/A
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Store Manager
16b. Kind of Business/Industry: Good Will Industries

17. Father's Name *(First, Middle, Last)*: Levi Clinton Barker
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Ida Burgess

19e. Interment's Neme/Reletionship *(Type, Print)*: Donald C. Whitt (Son)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 528 Beach Drive Baltimore, Maryland 21220

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel trom State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Moreland Memorial Park
Dete: 1-12-2001
20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funerel Service Licensee: Katha Lassahn Chamcki
22. Name end Address ot Fecility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in deeth)
e. Cerebrovascular accident — 4days
Due to (or es e consequence of):
b. possible colangiocarcinoma
Due to (or es e consequence ot):
Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy tindings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete ot Injury *(Month, Day Year)*
28b. Time ot Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, term, street, tectory, office building, etc. *(Specify)*
28t. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best ot my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: William Lighthart MD
29c. License number: AT2438946A14
29d. Dete signed *(Month, Day, Year)*: 1/10/2001

30. Neme and address ot person who completed cause of death (Item 23a) (Type, Print): William Lighthart, MD 201 East Universitypark way Baltimore MD 21218

State Registrar

31. Dete tiled *(Month, Day, Year)*: JAN 12 2001
32. Registrer's Signeture: Pamela D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00512

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jacqueline W Wise

2. Data of Death — Month: January Day: 9, Year: 2001

3. Time of Death: 11:07AM.

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-64-5402

6. Sex: 1☐ M 2☑ F

7. Age (In yrs/last birthday): 46 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): March 25, 1954

9. Birthplaca (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yas 2☐ No

10e. Street and Number: 3012 Oakley Ave.

10f. Zip Coda: 21215

10g. Citizan of What Country?: USA

11. Marital Status: 1☑ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☑ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☑ No Specify:

14. Raca - American Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grada complatad): Elementary/Secondary (0-12): 10th — Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): Homemaker

16b. Kind of Businass/Industry: Home

17. Father's Name (First, Middla, Last): John W. Wise

18. Mothar's Nama (First, Middle, Maidan Surnama): Ethel Brown

19a. Informant's Name/Ralationship (Type, Print): Muriel Tucker - Sister

19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 5200 Bowleys Ln. Apt. 314 Balto., MD. 21206

20a. Mathod of Disposition: 1☑ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): Mt. Zion Cemetery — Data: 1-16-01

20c. Location - City or Town, Stata: Lansdowne, MD.

21. Signature of Funaral Sarvica Licansaa: [signature]

22. Nama and Addrass of Facility: Gary P. March Funeral Home P.A. 2470 Fredhilton Pass Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or hamt failura. List only ona cause on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death):
a. Pulmonary Embolism — 30min.
Dua to (or as a consaquanca of):
b. Metastatic Cancer
Sequantially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of causa of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical axaminar? 1☐ Yas 2☒ No

26. Placa of Death (Chack only ona): Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only ona): 1☒ **Certifying Physician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar statad.

29b. Signature and title of cartifiar: [signature] TAH

29c. Licansa number: RES 000

29d. Data signad (Month, Day, Yaar): January 9, 2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): HENRY TAH, 2401 West Belvedere Ave, Baltimore, MD 21215

State Registrar

31. Data filad (Month, Day, Yaar): JAN 12 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wise, Jacqueline

68760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00513

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Peter J. Wilhide
2. Date of Death Month: Jan Day: 5 Year: 2001
3. Time of Death: 7:02 AM
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212 64 7274
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 6, 1956
9. Birthplace (State or Foreign Country): Washington D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1824 Log Lane
10f. Zip Code: 21114
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman
16b. Kind of Business/Industry: Amtrack

17. Father's Name (First, Middle, Last): Paul N. Wilhide
18. Mother's Name (First, Middle, Maiden Surname): Erthel P. Gilmore

19a. Informant's Name/Relationship (Type, Print): Christie L. Wilhide Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1824 Log Lane Crofton Maryland 21114

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Memorial Gardens — Date: Jan. 10, 2001
20c. Location - City or Town, State: Frederick Maryland

21. Signature of Funeral Service Licensee: Robert E. Evans
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. acute myocardial infarction — immediate
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffrey Bugg MD
29c. License number: D28640
29d. Date signed (Month, Day, Year): Jan 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2414 Hightee Ct. Crofton Md 21114

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00514

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROSE WILLIAMS
2. Date of Death (Month, Day, Year): JAN 7 2001
3. Time of Death: 2:00am
4a. Facility Name *(If not institution, give street and number)*: 480 Mirabille Ave.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 421-36-1047
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 20 1927
9. Birthplace *(State or Foreign Country)*: England

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 480 Mirabille Ave.
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: James Timmins
18. Mother's Name *(First, Middle, Maiden Surname)*: Theresa PArtin

19a. Informant's Name/Relationship *(Type, Print)*: Bill Williams /husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 480 Mirabille Ave. Baltimore MD 21224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.
Date: 1/9/2001
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex, 300 Mace AVe. Baltimore MD 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myeloid Leukemia — Months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Alan S Halle MD
29c. License number: D41614
29d. Date signed *(Month, Day, Year)*: January 9, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan B. Halle 4920 Campbell Blvd Baltimore, MD 21236

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: ▶ G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00515

WILLIAM WINGATE SR.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Harvey Wingate, Jr.

2. Date of Death (Month, Day, Year): January 8 2001

3. Time of Death: 10:30 A.M.

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-16-9663

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 20, 1925

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 18 East Heath Street

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Army 50-52

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): William Harvey Wingate, Sr.

18. Mother's Name (First, Middle, Meiden Surname): Gordice Pritchert

19a. Informant's Name/Relationship (Type, Print): Anita M. Phaneus / Girlfriend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7703 Oakwood Road, Apt # 103, Glen Burnie MD 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Crownsville Veterans Cem. Date: 01/11/2001

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. Lung Cancer — 8 Months

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other signifcant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place ot Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner ot Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time ot Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece ot Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43977

29d. Date signed (Month, Day, Year): January 8 2001

30. Name and address ot person who completed ceuse ot death (Item 23a) (Type, Print): Ayoka Olaniyi. 301 Hospital Drive. Glen Burnie. MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Geneva G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

01-0095-001
Stanley E. Bryant, Jr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00516

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STANLEY EDWARD BRYANT, JR.

2. Date of Death (Month, Day, Year): January 05, 2001

3. Time of Death: 7:25PM

4a. Facility Name (If not institution, give street and number): Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 216-72-7135

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 10, 1957

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: W.VA.

10b. County: Mineral

10c. City, Town or Location: Fort Ashby

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 122 Evergreen Drive

10f. Zip Code: 26719

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pipefitters Union

16b. Kind of Business/Industry: Pipefitter

17. Father's Name (First, Middle, Last): Stanley Edward Bryant, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Gloria Dean

19a. Informant's Name/Relationship (Type, Print): Debra A. Bryant Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 122 Evergreen Dr., Fort Ashby, W.VA. 26719

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cumberland Crematory

Date: Jan 9, 2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ Dale L. Merritt per DVR

22. Name and Address of Facility: Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Chest and abdominal injuries and positional asphyxia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 1-05-01

28b. Time of Injury: 1915 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Driver in auto accident.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Rte 956/Waxler Rd., Mineral Co., W.VA.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: OCME

29d. Date signed (Month, Day, Year): January 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke, M.D., 111 Penn St., Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: ▶ [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

* permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00517

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shirley Gene Carter

2. Date of Death (Month, Day, Year): January 3, 2001

3. Time of Death: 1310

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 213-42-9919

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 8, 1942

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Inside City Limits: ☒Yes 2☐No

10e. Street and Number: 903 7th Street

10f. Zip Code: 20707

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 10

College (1-4or 5+): Ø

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Hallie Hostetter

18. Mother's Name (First, Middle, Maiden Surname): Nellie Wilhem

19a. Informant's Name/Relationship (Type, Print): Ralph Carter/Husband

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 903 7th Street, Laurel, MD 20707

20a. Method of Disposition: ☒Buriel 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Columbia Memorial Park

Date: 1/8/01

20c. Location - City or Town, State: Columbia, Maryland

21. Signature of Funeral Service Licensee: [signature] Moll03

22. Name end Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester, DO

29c. License number: H0055927

29d. Date signed (Month, Day, Year): January 4, 2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

01-0023-033
CJ
Jeanette Carbaugh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM 19a per inf G793 032801 SS
AMEND# 23&27 per ME G793 030901 SS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00518

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Jeanette Marie Carbaugh	January	01	2001	02:02 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-82-6205	1☐ M 2☒ F	39 Yrs.			Dec. 6, 1961	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Edmonston	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5118 Kenilworth Avenue #5	20781	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elemantary/Secondary (0-12)	Collega (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Howell R. Jarman, Jr.	Janet D. Price

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Janet D. ~~Harman~~ Jarman - Mother	5125 Emerson Street, Edmonston, Maryland 20781

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetery, cremetory or othar piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)	Fort Lincoln Cemetery	1/8/2001	Brentwood, Maryland

21. Signature of Funeral Service Licensee	22. Neme and Address of Feciliity
Dorothy Jean Wirth	Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23e. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Intervel Between Onsat and Death
Immediete Cause (Finel diseese or condition resulting in death)	a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or as e consequenca of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Due to (or as a consequance of):	
	c. Due to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. King	O.C.M.E.	January 2, 2000

30. Name and address of person who completed cause of death (item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 04 2001	

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0121-031
CJ
Jason Michael
Gregory amend item 23a,ptII,27,28a-f per me G792 2/13/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00519

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jason Michael Gregory
2. Date of Death: Month January, Day 07, Year 2001
3. Time of Death: 06:03 A.M.
4a. Facility Name (If not institution, give street and number): 8 Copps Hill Court
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-59-3030
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months 3, Days
If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept.22, 2000
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8 Copps Hill Court
10f. Zip Code: 20886
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): N/A
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Jason Michael Condon
18. Mother's Name (First, Middle, Maiden Surname): Carrie Lynn Gregory

19a. Informant's Name/Relationship (Type, Print): Carrie L. Gregory/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Copps Hill Court, Gaithersburg, MD 20886

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 1/10/01
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Laurie Donaldson M00160
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. SUFFOCATION DUE TO OBSTRUCTION OF AIRWAY BY A PILLOW

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 1/7/01
28b. Time of Injury: found 5:30 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject suffocated
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 8 Copps Hill Court, Gaithersburg, Md

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00520

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Louise Harding

2. Date of Death (Month, Day, Year): January 8, 2001

3. Time of Death: 6:45PM

4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 217-14-7922

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr. 13, 1922

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9410 Fairview Avenue

10f. Zip Code: 20723

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+): Ø

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Assistant

16b. Kind of Business/Industry: Department Store

17. Father's Name *(First, Middle, Last)*: Frank George Rice, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Maude Leaman

19a. Informent's Name/Relationship *(Type, Print)*: Vernon Richard Harding/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9410 Fairview Avenue, Laurel, MD 20723

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Pk | Date: 1/12/01

20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: [signature] M00773

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus-Insulin Dependent

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] William A Warren MD

29c. License number: D13916

29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William A. Warren, 321 Prince George Street, Laurel, MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: [signature]

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ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00521

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Rachel E. Moore
2. Dete of Deeth — Month: January Day: 10 Year: 2001
3. Time of Death: 12:00am
4e. Feciility Neme (If not institution, give street end number): St. Agnes Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Ellicott City
4c. County of Deeth: Howard

Funeral Director

5. Sociel Security Number: 215 03 2531
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): June 25, 1911
9. Birthpiece (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3766 Plum Meadow Drive
10f. Zip Code: 21042
10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: Retail

17. Father's Neme (First, Middle, Last): William Erline
18. Mother's Name (First, Middle, Maiden Surneme): Rachel Barry

19a. Informent's Name/Reletionship (Type, Print): Ellen Murphy/Daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3766 Plum Meadow Drive Ellicott City, MD 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Baltimore Cemetery
Dete: 1-12-2001
20c. Location - City or Town, Stete: Baltimore, MD

21. Signeture of Funeral Service Licensee: Steve A Collins-Wolfe MO1044
22. Neme end Address of Feciility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth)
a. STROKE (CEREBROVASCULAR DISEASE) — (WEEK

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest
b.

Due to (or es e consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

28. Piece of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es stated. 2☐ **Medicel Examiner:** On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner stated.

29b. Signeture and titie of certifier: James P. Richardson MD
29c. License number: D 27394
29d. Date signed (Month, Dey, Yeer): January 10, 2001

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): JAMES P. RICHARDSON MD 700 GEORGE ROAD, COCKEYSVILLE, MD 21228

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 11 2001
32. Registrer's Signature: Donna G. Sparks

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CPS
00-0038-017
DONTE NICHOLAS
AMEND# 23b per ME G793 030701 SS
amend item 23a,27,28a,b,c,d,e,f per me G791 1/17/01 yfg

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00522

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donte Savoy Nicholas
2. Date of Death (Month, Day, Year): JANUARY 2, 2001
3. Time of Death: 8:30 PM
4a. Facility Name (If not institution, give street and number): 2495 Brigham Court
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 212-13-4935
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 14 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 21, 1986
9. Birthplace (State or Foreign Country): Cheverly, Md.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2495 Brigham Ct.
10f. Zip Code: 20603
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: N/A
17. Father's Name (First, Middle, Last): Kenneth Washington
18. Mother's Neme (First, Middle, Maiden Surneme): Anissa Nicholas
19a. Informant's Name/Relationship (Type, Print): Brenda Nicholas/ Grandmother
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3618 Stonesboro Rd. Ft. Washington, Md. 20744
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): Harmony Memorial Park
Date: 1/11/01
20c. Location - City or Town, Steta: Landover, Md.
21. Signeture of Funerel Service Licensee: Kenneth A. Turner M01085
22. Name end Address of Fecility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death): a. CONTACT SHOTGUN WOUND OF CHEST

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of deeth? ☒ Yes 2☐ No

25. Was case referred to medicel examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) scene

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1/2/01
28b. Time of Injury: 6:30 PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject shot self
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify): residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2495 Brigham Court, Waldorf, Md

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, end dua to the cause(s) and menner steted.

29b. Signature and title of certifier: M.D.
29c. License number: OCME
29d. Dete signed (Month, Dey, Year): January 3, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): JAN 0 8 2001
32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit docs.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00523

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy C. O'Brien

2. Data of Death Month / Day / Year: January 10, 2001

3. Time of Death: 7:16 am

4a. Facility Name *(If not institution, give street and number)*: ST. Agnes Hospital 900 caton Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: None

Funeral Director

5. Social Security Number: 215 64 4209

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 9, 1925

9. Birthplace *(State or Foraign Country)*: Maryland

Usuel Residence of Decedant

10a. Stete: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4786 Bonnie Branch Road

10f. Zip Code: 21043

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☐ No If Yes, Giva Yaar or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* white

15. Decedant's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Teacher's Aid

16b. Kind of Businass/Industry: Education

17. Fathar's Nama *(First, Middle, Last)*: Harry C. Walterhoefer Sr.

18. Mothar's Name *(First, Middle, Meiden Surname)*: Rolandis Weigman

19a. Informant's Name/Relationship *(Type, Print)*: Charles W. O'Brien Sr./Husband

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 4786 Bonnie Branch Road Ellicott City, MD 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, cramatory or othar placa)*: Loudon Park Cemetery | Data: 1-12-2001

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funaral Service Licensee: ▶ Shana Collins-Witzke mo1044

22. Nama and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician* /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona cause on aach lina.

Approximate Intarval Batwean Onset and Death

Immediate Cause (Final diseasa or condition resulting in death)
a. Sepsis — days
Dua to (or as a consequanca of):
b. Pneumonia — days
Dua to (or as e consequence of):

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disaasa or injury that initieted events rasulting in death) Last
c. Chronic Obstructive Pulmonary disease — years
Dua to (or es a consequance of):
d. Congestive Heart Failure — days

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse givan in Part I.

Dementia

Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarred to medical exeminar? 1☐ Yas 2☒ No

26. Place of Deeth *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yas 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, deta and placa, and dua to the cause(s) and mannar stated.

29b. Signeture and title of certifier: ▶ Sohair Yousif S MD.

29c. Licansa number: 13133

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): SOHAIR YOUSIF 900 Caton Ave Baltimore, MD 21229

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME O'BRIEN, DOROTHY C

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

UNCLASSIFIED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00524

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth Earl Padrick Jr.

2. Date of Death: Month: January Day: 7 Year: 2001

3. Time of Death: 6:15pm

4a. Facility Name (If not institution, give street and number): 3903 Palmira Lane

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212 76 3047

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 3, 1960

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3903 Palmira Lane

10f. Zip Code: 20906

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Iron Worker

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Kenneth Earl Padrick Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mildred Spivey

19a. Informant's Name/Relationship (Type, Print): Allyson S. Padrick/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3903 Palmira Lane Silver Spring , MD 20906

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 1-11-2001

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Sheila Collins-Wyche MD1044

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Renal cell cancer — 3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D35635

29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr Kaplan 18111 Prince Phillip Dr Ste 327 Olney MD 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00525

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gertrude Theresa Russell
2. Data of Death Month Day Year: January 4, 2001
3. Time of Death: 8:20 a.m.
4a. Facility Name *(If not institution, giva street and number)*: 1007 8th Street
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 213-28-9361
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Sept 27, 1912
9. Birthplace *(State or Foraign Country)*: Maryland

Usual Rasidance of Decedant

10a. Stata: Md.
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 1007 8th Street
10f. Zip Coda: 20707
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada compiatad)*: Elamantary/Secondary (0-12): Grade 7 / Collaga (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Fathar's Name *(First, Middla, Last)*: Charles William Hinton
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Augusta Virginia Gladman

19a. Informant's Name/Relationship *(Type, Print)*: Mary Frances Johns/daughter
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1007 8th Street Laurel, Maryland 20707

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Metro Crematory, Inc.
Data: Jan. 5, 2000
20c. Location - City or Town, Stata: Catonsville, Maryland

21. Signature of Funaral Sarvice Licensaa: ▶ Gary S. Kyer /M00770
22. Nama and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that causad the daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each lina.

Approximata Intarval Between Onsat and Death

Immediate Cause (Final disaasa or condition rasulting in death)
a. Cerebrovascular Accident — minutes
Due to (or as s consequence of):
Hypertension — years

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaasa or injury that initiated avents rasulting in death) Last
b. Dua to (or as a consequance of):
c. Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco uss contributa to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☒ Rasidence 6☐ Othar *(Specify)*
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describa how injury occurrad
28a. Placa of Injury - At home, farm, streat, factory, office building, atc. *(Spacify)*
28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.
29b. Signature and title of cartifiar: ▶ William A Warren MD
29c. Licansa number: D13516
29d. Date signed *(Month, Day, Year)*: January 5, 2001
30. Nama and address of person who complatad causa of death (Item 23a) (Type, Print): William A. Warren, MD 321 Prince George Street Laurel, Maryland 20707

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 08 2001
32. Registrar's Signature: ▶ Donna G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(12)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00526

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Keys Stanton

2. Deta of Death: Month January Dey 06, Yeer 2001

3. Time of Deeth: 7:15 am

4e. Facility Neme (If not institution, giva street and number): Morningside House

4b. City, Town, or Location of Deeth: Laurel

4c. County of Death: Prince George

Funeral Director

5. Sociel Security Number: 215-38-2562

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 25, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Prince George

10c. City, Town or Location: Laurel

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 7700 Cherry Lane

10f. Zip Coda: 20707

10g. Citizan of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No Specify:

14. Raca - American Indian, Bteck, Whita, atc.: Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Public Schools

17. Father's Neme (First, Middle, Last): Clayton S. Keys

18. Mother's Name (First, Middle, Maiden Surneme): Rose Anderson

19e. Informant's Neme/Reietionship (Type, Pnnt): Janice B. Loftus /per. rep.

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 606 Wiss Drive, Laurel, Maryland 20707

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removei from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cematary, crematory or other place): Ivy Hill Cemetery

Dete: 1/10/01

20c. Location - City or Town, Stete: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00773

22. Name end Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the daath. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disaase or condition resulting in death)

e. Cerebrovascular Accident — Minutes

Due to (or es e consequence of):

Sequentiellty list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest

b. Hypertension

Due to (or es e consequenca of):

c.

Due to (or es e consequance of):

d.

Part ii. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availabla prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other (Specify) Assisted Living

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Couid not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of injury M

28c. injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, data end pieca, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: ▶ William A Warren

29c. License number: D13966

29d. Data signed (Month, Day, Year): January 8, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): William Warren 321 Prince George Street, Laurel, MD 20707

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year): JAN 08 2001

32. Registrer's Signeture: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00527

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOROTHY E. SMITH

2. Date of Death Month Day Year: January 3 2001

3. Time of Death: 9:20 PM

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-32-0196

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 2-13-1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County-White Marsh

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11606 Jerome Avenue

10f. Zip Code: 21162

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 yrs. | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Clerk

16b. Kind of Business/Industry: Retail Sales

17. Father's Name *(First, Middle, Last)*: Ernest Pheobus

18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie Andrews

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Melvin T. Smith

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11606 Jerome Avenue White Marsh, Md. 21162

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery | Date: 1-6-2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Melvin T. Clark

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lymphoma

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RD 199943

29d. Date signed *(Month, Day, Year)*: January 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Todd LaRabee 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Smith Dorothy

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00528

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lillian R Thornton
2. Deta of Death Month: January Day: 10 Yeer: 2001
3. Time of Death: 1215am
4e. Facility Name *(If not institution, give street and number)*: Howard County Goneral Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 217 14 6039
6. Sex: 1☐ M 2☒F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 24,1921
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Insida City Limits: 1☐ Yas 2☒No
10e. Street and Number: 10916 Battersea Lane
10f. Zip Code: 21044
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒No If Yes, Giva Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+):
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper
16b. Kind of Business/Industry: College
17. Father's Name *(First, Middle, Last)*: Harry Baker
18. Mother's Neme *(First, Middle, Maiden Surname)*: Ivy Holsner
19e. Informant's Name/Relationship *(Type, Print)*: John G. Belding/Son in law
19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10564 Owen Brown Road Columbia, MD 21044
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stala 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Date: 1-12-2001
20c. Location - City or Town, Stete: Catonsville, MD
21. Signeture of Funeral Service Licensee: Shena A Collins-Wolfe MO1044
22. Name end Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart taiture. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. Pneumonia
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last: b. COPD
Due to (or es a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Dfd **tobacco use** contribute to **the causa** of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, siraal, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete end ptaca, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: Elizabeth Bower MD
29c. License number: D55437
29d. Data signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elizabeth Bower, MD 3460 Ellicott Center Drive #103 Ellicott City, MD 21043

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: Sue G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00529

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward M. Walenta
2. Date of Death Month / Day / Year: January 7, 2001
3. Time of Death: 11:57PM
4a. Facility Name *(If not Institution, give street and number)*: Montgomery County General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 167-03-3725
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 15, 1911
9. Birthplace *(State or Foreign Country)*: Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: PA
10b. County: Westmoreland
10c. City, Town or Location: New Kensington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 229 Main Street
10f. Zip Code: 15068
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tool & Die Maker
16b. Kind of Business/Industry: PPG Glass Co.

17. Father's Name *(First, Middle, Last)*: Martin J. Walenta
18. Mother's Name *(First, Middle, Maiden Surname)*: Evelin Stupka

19a. Informant's Name/Relationship *(Type, Print)*: Edward R. Walenta/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13401 Green Hill Court, Highland, MD 20777

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: St. Mary's Cemetery
Date: 1/12/01
20c. Location - City or Town, State: Lower Burrell, PA

21. Signature of Funeral Service Licensee: Janice Ahern MO1103
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — immediate

Due to (or as a consequence of):
b. Coronary Artery Disease — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation
Hyperlipoidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D34018
29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas Argento MD 14201 Laurel Park Drive Laurel MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: Donna G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(10)

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 00530

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther Dena Waskow
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 7:17P.
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 224-14-2024
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 18, 1922
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15101 Interlachen Drive, #101
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Secretary
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Louis Samuel Salsbury
18. Mother's Name (First, Middle, Maiden Surname): Lena Aronson

19a. Informant's Name/Retelionship (Type, Print): Julius Waskow - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10a - 10g

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Lebanon Cemetery | Date: 1/7/2001
20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiogenic Shock	2days
Due to (or as a consequence of): b.	Myocardial Infarction	2days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Coronary Artery Disease	10years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypercarbic Respiratory Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David B. Magliaro MD
29c. License number: D51908
29d. Date signed (Month, Day, Year): January 4 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David B. Magliaro MD 18111 Prince Phillip Drive Olney Maryland 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00531

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sylvia Mecchia Austin
2. Date of Death Month Day Year: January 9 2001
3. Time of Death: 6:55PM
4a Facility Name *(If not institution, give street end number)*: 6701 Golden Ring Road
4b. City, Town, or Location of Death: Baltimore County
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216 30 0984
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 8 1932
9. Birthplace *(State or Foreign Country)*: New York, New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☐ No X
10e. Street and Number: 6701 Golden Ring Road
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher
16b. Kind of Business/Industry: Baltimore County Board of Education

17. Father's Name *(First, Middle, Last)*: Basil Mecchia
18. Mother's Name *(First, Middle, Maiden Surname)*: Pierina Vachino

19a. Informant's Name/Relationship *(Type, Print)*: Jennifer A Austin
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 849 Fairmount Ave Suite 300 Baltimore, Maryland 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc. — Date: January 13 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Heather Lassahn Chojnacki
22. Name and Address of Facility: Lassahn Funeral Home INc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary edema
Due to (or as a consequence of):
b. Congestive heart failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hemangiopericytoma (cardiac)
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Vincent P Wroblewski MD-physician
29c. License number: D43031
29d. Date signed *(Month, Day, Year)*: 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VINCENT P. WROBLEWSKI, MD 1623 Bellona Avenue Lutherville, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00532

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Phyllis H. Ander
2. Date of Death Month Dey Year: JANUARY 14, 2001
3. Time of Death: 12:30 PM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-18-7496
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/30/21
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8810 Walther Blvd. #3112
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accounting
16b. Kind of Business/Industry: Black & Decker

17. Father's Name *(First, Middle, Last)*: Charles Sope Hildebrand
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Tyrrill

19a. Informant's Name/Relationship *(Type, Print)*: Laurie Gassman Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18 Linden Terrace Towson, MD 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.
Date: 1/16/01
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Heather N. Harp
22. Name and Address of Facility: The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. END STAGE CHRONIC OBSTRUCTIVE

Due to (or as a consequence of):
b. PULMONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joginder P Mehta M.D
29c. License number: D 41410
29d. Date signed *(Month, Day, Year)*: January 15th, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 16 2001
32. Registrar's Signature: ▶ Jenna D Spates

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00533

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen R. Antoniacci

2. Date of Death Month Day Year: January 13, 2001

3. Time of Death: 12:35 AM

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 170-10-0582

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 5, 1911

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Pennsylvania

10b. County: Lackawanna

10c. City, Town or Location: Scranton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1800 E. Mountain Road

10f. Zip Code: 18505

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retail Manager

16b. Kind of Business/Industry: Clothing

17. Father's Name *(First, Middle, Last)*: Josef Filipski

18. Mother's Name *(First, Middle, Maiden Surname)*: Maria (unavailable)

19a. Informant's Name/Relationship *(Type, Print)*: Gene E. Antoniacci/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6909 Horizon Terrace, Derwood, Maryland 20855

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Sacred Heart Cemetery

Date: Jan. 17, 2001

20c. Location - City or Town, State: Minooka, Pennsylvania

21. Signature of Funeral Service Licensee: Robert A. Pumphrey M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediate Cause (Final disease or condition resulting in death) a.	Ischemic Cardiomyopathy with Left Ventricular Congestive Heart Failure	1 week
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daeth) Last b.	Pneumonia	1 week
Due to (or as a consequence of):		
c.	Urinary Tract Infection	1 week
Due to (or as a consequance of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Essential Thrombocytosis

Coronary Atherosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Philip G. Henjum, M.D.

29c. License number: D35045

29d. Date signed *(Month, Day, Year)*: January 13, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Philip G. Henjum, M.D. 3416 Olandwood Ct. #204 Olney, Maryland 20832

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-207-510
HAKIEM I AMEER
JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00534

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAKIEM I. AMEER
2. Date of Death Month Day Year: JANUARY 13, 2001
3. Time of Death: 04:44 A.M.
4a. Facility Name (If not institution, give street and number): 518 QUAIL AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 105-62-4036
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 30 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): JUNE 17, 1970
9. Birthplaca (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☐ Yas 2 ☒ No
10e. Street and Number: 606 CARROLLWOOD ROAD
10f. Zip Coda: 21220
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedant Ever in U.S. Armed Forcas? 1 ☐ Yes 2 XX No If Yas, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yas 2 XX No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: BLACK

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12th grade | Collega (1-4or 5+): 3yrs
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): SANITATION WORKER
16b. Kind of Business/Industry: SANITATION

17. Father's Nama (First, Middla, Last): RICHARD REGEL
18. Mothar's Neme (First, Middla, Maidan Surname): JULIA M SMITH

19a. Informant's Name/Ralationship (Type, Print): Julia M. Smith/Mother
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 226-11 130th Avenue, Laurelton, New York, 11413

20a. Mathod of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Name of camatery, crematory or other placa): NASSAU KNOLLS/MEM PARK
Data: 1-20-01
20c. Location - City or Town, State: PORT WASHINGTON, N.Y.

21. Signature of Funeral Service Licensee: Charles F. Powell
22. Nama and Addrass of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha daath. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one causa on each line. (Approximata Intarval Between Onset and Death)

Immediete Cause (Final disaasa or condition rasulting in deeth): a. MULTIPLE GUNSHOT WOUNDS
Dua to (or as a consaquanca of):

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last:
b. Dua to (or as a consaquanca of):
c. Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yas 2 ☐ No
24b. Ware autopsy findings available prior to completion of causa of death? 1 ☒ Yas 2 ☐ No

25. Was casa referred to medical examinar? 1 ☒ Yas 2 ☐ No
26. Plece of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☒ Othar (Specify) SCENE

27. Mennar of Deeth: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicida 5 ☐ Panding invastigation 6 ☐ Could not be determined
28a. Deta of Injury (Month, Day Year): 1/13/01 FOUND
28b. Tima of Injury: FOUND 0442 M
28c. Injury at Work? 1 ☐ Yas 2 ☒ No
28d. Describe how injury occurred: SUBJECT WAS SHOT
28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify): A RESIDENCE
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata): 518 QUAIL AVE, BALTIMORE, MD

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha ceuse(s) and manner as stated. 2 ☒ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, date and ptace, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: [signature], M.D.
29c. License number: O.C.M.E.
29d. Data signed (Month, Day, Year): JANUARY 13, 2001

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): MARY G. RIPPLE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00535

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Arthur

2. Date of Death: Month January Day 11 Year 2001

3. Time of Death: 11:10 pm

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 020-12-1339

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 2, 1922

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9106 Dunloggin Rd.

10f. Zip Code: 21042

10g. Citizen of What Country? United States

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Broker

16b. Kind of Business/Industry: Real Estate

17. Father's Neme (First, Middle, Last): Walter E. Jewell

18. Mother's Neme (First, Middle, Maiden Sumeme): Maude Bartlett

19a. Informent's Name/Relationship (Type, Print): Virginia Russell / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9106 Dunloggin Rd. Ellicott City, MD. 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): Newton Cemetery

Date: Jan.16 2001

20c. Location - City or Town, State: Newton, Massachusetts

21. Signeture of Funeral Service Licensee: [signature] M01041

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SUDDEN DEATH — minuts

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — 10 years

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☐ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: [signature] MD

29c. License number: D51560

29d. Date signed (Month, Day, Year): Jan 12, 2001

30. Name and address of person who completed cause of deeth (item 23a) (Type, Print): JONATHAN FOX MD 3460 ELLICOTT CTR DR #103 ELLICOTT CITY MD 21043

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00536

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Della Mae Bentley
2. Date of Death Month 01 Day 09 Year 2001
3. Time of Death: 9:21 A.M.
4e. Facility Neme (If not institution, give street and number): 2057 Glencove Road
4b. City, Town, or Location of Death: Darlington
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-30-6296
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): Oct. 10, 1920
9. Birthplece (State or Foreign Country): Kentucky

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Harford
10c. City, Town or Location: Darlington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2057 Glencove Road
10f. Zip Code: 21034
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 yrs; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: At Home

17. Father's Neme (First, Middle, Last): Henry Mullins
18. Mother's Name (First, Middle, Maiden Surname): Bessie Dingus

19e. Informant's Neme/Relationship (Type, Print): Dorothy Parks
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2057 Glencove Road Darlington, Maryland 21034

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel - Bel Air, P.A.
Date: Jan. 10, 2001
20c. Location - City or Town, Stete: Forest Hill, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: Evans Funeral Chapel - Bel Air, P.A. 21050 3 Newport Drive Forest Hill Maryland

Physician /Medical Examiner

23e. Pert 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Final disease or condition resulting in deeth): e. Arteriosclerotic cardiovascular disease

Due to (or as a consequence of): b. Dementia

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es a consequence of): c. Degenerative Arthritis

Due to (or es e consequence of): d.

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: [signature] M.D.
29c. License number: D20661
29d. Date signed (Month, Day, Year): January 10, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Jean T. Lee, M.D., 669 Revolution St., Havre de Grace, MD. 21078

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00537

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANASTASIA BENGERMINO

2. Date of Death — Month: JANUARY Day: 15th Year: 2001

3. Time of Death: 8:45 PM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 216-07-6099

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 8 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2936 Edgewood Ave

10f. Zip Code: 21234

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondery (0-12): 12 — College (1-4or 5+): —

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): Frank Fiori

18. Mother's Name (First, Middle, Maiden Surname): Concetta Sorrentino

19a. Informant's Name/Relationship (Type, Print): Louis J. Bangermino

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2936 Edgewood Ave. Baltimore, Md 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Mem. Park — Date: Jan. 19 2001

20c. Location - City or Town, State: Parkville Md.

21. Signature of Funeral Service Licensee: ▶ Keith S. Wells

22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. BRAIN STEM CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Maharaj MD

29c. License number: D13457

29d. Date signed (Month, Day, Year): January 15th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROSEMARIE MAHARAJ C/O GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALT MD 21286

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: ▶ Denise S Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00538

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MICHAEL P. BEAM, SR.
2. Date of Death Month Day Year: JANUARY 14, 2001
3. Time of Death: 6 A.M.
4a. Facility Name *(If not institution, give street and number)*: 2610 CLAYTON ROAD
4b. City, Town, or Location of Death: JOPPA
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 212-62-5277
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 47 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV. 12, 1953
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: JOPPA
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2610 CLAYTON ROAD
10f. Zip Code: 21085
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 YRS. College (1-4or 5+): 2 YRS.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ELECTRICIAN
16b. Kind of Business/Industry: CORP. REALITY CO.

17. Father's Name *(First, Middle, Last)*: CLARENCE L. BEAM, JR.
18. Mother's Name *(First, Middle, Maiden Surname)*: AUDREY G. SHECKELLS

19a. Informant's Name/Relationship *(Type, Print)*: RITA L. BEAM
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2610 CLAYTON ROAD JOPPA, MARYLAND 21085

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: PARKWOOD CEMETERY
Date: JAN 17, 2001
20c. Location - City or Town, State: PARKVILLE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE, MARYLAND 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER (SQUAMOUS CELL) — 21 MONTHS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Philip W. Halstead MD
29c. License number: 050803
29d. Date signed *(Month, Day, Year)*: JANUARY 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP HALSTEAD, MD 1200 BRASS MILL ROAD BELCAMP, MARYLAND

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Lawrence G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00539

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
ANTHONY	BANKS		January	12	2001	11:50 P

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BON SECOURS HOSPITAL	BALTIMORE	CITY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-64-6170	1 [X] M 2 [ ] F	43 Yrs.					MAR. 24, 1957	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	[X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2861 W. LANVALE STREET	21216	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th	NA	LABORER	FACTORY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ERIC BANKS	SYLVIA WARE

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SYLVIA FISHER (MOTHER)	2861 W. LANVALE STREET BALTIMORE, MD 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	MT ZION CEMETERY	1/17/01	LANSDOWNE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. MASSIVE BLEEDING	DAYS
Due to (or as a consequence of):	b. ESOPHAGEAL VARICES	MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. LIVER CIRRHOSIS	MONTHS
Due to (or as a consequence of):	d. ALCOHOL	YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACQUIRED IMMUNO DEFICIENCY SYNDROME.

POLYSUBSTANCE ABUSE

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D19057	January 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PELAYO E. CORREA MD BON SECOURS HOSPITAL

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00540

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nancy M. Brooks
2. Date of Death (Month, Day, Year): JANUARY 11, 2001
3. Time of Death: 4:15 PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-40-7566
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 25, 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7 Paula Place Apt 1A
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Robert Roby
18. Mother's Name (First, Middle, Maiden Surname): Helen Zalenski

19a. Informant's Name/Relationship (Type, Print): Lyle Brooks/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Paula Place Apt 1A Baltimore, MD 21237

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 1-12-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC PAROTID CARCINOMA — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Natividad D. de Leon, M.D.
29c. License number: D19508
29d. Date signed (Month, Day, Year): 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NATIVIDAD D. de Leon, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00541

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie G. Basili

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 5:50AM

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 117-28-5723

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 17, 1905

9. Birthplace (State or Foreign Country): Italy

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13716 Bridgewater Drive

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): | College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Insurance & Travel

17. Father's Name (First, Middle, Last): John Tesoriero

18. Mother's Name (First, Middle, Maiden Surname): Germania Giuffee

19a. Informant's Name/Relationship (Type, Print): Victor Basili-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13716 Bridgewater Drive, Silver Spring, Maryland 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery | Date: 01/19/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland21228

Permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. End Stage Alzheimer's-type dementia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy tindings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the besis of exemination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D47009

29d. Date signed (Month, Day, Year): January 14, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Phillip Stone, 711 Maiden Choice Lane, Baltimore MD 21228

To the Hospital or Attending Physician: Tha law requiras that the daath cartificata be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attanding physician and completely filled in by the funeral director, paga 2 should be datached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrer's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00542

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Norma Brinson
2. Dete of Deeth (Month, Dey, Yeer): January 11 2001
3. Time of Deeth: 2345
4e. Facility Neme (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death: N/A

Funeral Director

5. Sociel Security Number: 217-34-2548
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 12/11/1937
9. Birthplace (State or Foreign Country): Virginia

Usuel Residence of Decedent

10e. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: White Marsh
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8701 Walther Blvd.
10f. Zip Code: 21236
10g. Citizen of Whet Country?: USA
11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, Whita, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8th Grade; College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Neme (First, Middle, Last): James Batten
18. Mother's Neme (First, Middle, Meiden Surneme): Virginia Gibson
19e. Informent's Neme/Reletionship (Type, Print): Floyd Brinson Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8701 Walter Blvd. Baltimore, MD 21236
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem. Dete: 1/15/2001
20c. Location - City or Town, Stete: Parkville, MD
21. Signeture of Funeral Service Licensee: Heather N. Hayes
22. Neme end Address of Feciility: The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21286

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immedlete Cause (Finel disease or condition resulting in deeth)	e. Metastatic Small Cell Carcinoma	3 years
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest	b. Due to (or es e consequence of):	
	c. Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of exemineticn and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Pearl Luber MD
29c. License number: D0055998
29d. Date signed (Month, Day, Year): January 15, 2001

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Pearl Luber MD Good Samaritan Hospital 5601 Loch Raven Blvd. Baltimore, MD 21239

State Registrar

31. Dete filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signeture: Donna B Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00543

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOE LEE BUFFALOE

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 2354

4a. Facility Name (If not institution, give street and number): SAINT AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/C

Funeral Director

5. Social Security Number: 212-48-0236

6. Sex: [X] 1 M [ ] 2 F

7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR 15 1949

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: [X] 1 Yes [ ] 2 No

10e. Street and Number: 4313 FLOWERTON ROAD

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: [ ] 1 Never Married [ ] 2 Married [ ] 3 Widowed [X] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Engineer Supervisor

16b. Kind of Business/Industry: MTX INDUSTRIAL SERVICE GROUP

17. Father's Name (First, Middle, Last): ALPHONSO BUFFALOE

18. Mother's Name (First, Middle, Maiden Surname): GRACE LEE

19a. Informant's Name/Relationship (Type, Print): Grace Buffaloe/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4313 Flowerton Rd., Baltimore, Md., 21229

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST

Date: 1-19-01

20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Charles A. Bartell

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA, 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE MYOCARDIAL INFARCTION — 1 hour

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, HYPERTENSION, RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [ ] 2 No [ ] 3 Probably [X] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death (Check only one): Hospital: [ ] 1 Inpatient [ ] 2 ER/Outpatient [X] 3 DOA; Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 6 Other (Specify)

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jerome I. Snyder M.D.

29c. License number: D22648

29d. Date signed (Month, Day, Year): JANUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEROME I. SNYDER, M.D. 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [illegible] Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

BUFFALOE, JOE

1+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00544

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leonard Brown

2. Date of Death (Month, Day, Year): January 11 2001

3. Time of Death: 10:20 pm

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-23-9339

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 21, 1950

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2304 Aiken Street

10f. Zip Code: 21218

10g. Citizen of What Country? United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Meals on Wheels

17. Father's Name (First, Middle, Last): Leonard E. Sutton, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Viola Brown

19a. Informant's Name/Relationship (Type, Print): Mrs. Evelyn Dickenson-Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2304 Aiken Street, Baltimore, MD 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Park

Date: Jan 17 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Calvin L. Williams

22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cerebral Hemorrhage — Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: Res-000

29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Adam Fleisher Path 509, 601 Wolfe St JHH

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Bonnie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #10E PER F.H. G791 1-16-01 WR.

Certificate of Death

Reg. No. 2001 00545

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOROTHY IDA MOHR BRUGGEMANN
2. Date of Death (Month, Day, Year): January 9, 2001
3. Time of Death: 1:30 AM
4a. Facility Name *(If not institution, give street and number)*: DULANEY-TOWSON HEALTH CARE CENTER
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 219-16-8488
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 28, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore County
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 111 WEST ROAD ~~1111 West Road~~
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Residence

17. Father's Name *(First, Middle, Last)*: Henry George Mohr
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Anna Gumbert

19a. Informant's Name/Relationship *(Type, Print)*: M. Anne Timmerman (Sister)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 28 Allegheny Avenue, Towson, Maryland 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery
Date: 1/11/2001
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — 1 Day

Due to (or as a consequence of):
b. METASTATIC BLADDER CANCER — 2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
GENERALIZED ARTERIOSCLEROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D22609
29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RUBON REIDER, M.D., 7445 A Furnace Branch Road, Glen Burnie, Maryland 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00546

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stephen Basarab
2. Date of Death (Month, Day, Year): Jan. 12, 2001
3. Time of Death: 10:40 pm
4a. Facility Name (If not institution, give street and number): 2958 WYMAN PARKWAY
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 200-05-2043
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 13, 1913
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residance of Decedent

10a. Steta: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2958 WYMAN PARKWAY
10f. Zip Code: 21211
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): AGENT
16b. Kind of Business/Industry: INTERNAL REVENUE SERVICE

17. Father's Name (First, Middle, Last): ONUFREY BASARAB
18. Mother's Name (First, Middle, Maidan Surname): MARY KOPIJCHAK

19a. Informent's Name/Ralationship (Type, Print): WANDA BASARAB/ WIFE
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2958 WYMAN PARKWAY, BALTIMORE, MARYLAND 21211

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): WOODLAWN CEMETERY | Date: 1/15/01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on aach lina. | Approximate Intarval Batween Onset and Death

Immediate Causa (Final disease or condition resulting in deeth)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding invastigation 6 [ ] Could not be detarmined
28a. Dete of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to the causa(s) and manner stated.
29b. Signature and title of certifier: W. M. Smith
29c. License number: D1-807
29d. Date signed (Month, Day, Year): 1/13/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. M. Smith 1900 E. North Pkwy Balto. MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM :# 7, 8 PER INFORMANT GH791 1-26-01 WR.

Certificate of Death

Reg. No. 2001 00547

Boyer, William
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): WILLIAM R BOYER

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 10:20 AM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-28-7865

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 70 ~~64~~ Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/27/30 ~~Nov. 27 1936~~

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4 E Mersey Court

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent ot Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 8th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical

16b. Kind of Business/Industry: Crown Electric

17. Father's Name (First, Middle, Last): Russell D Boyer

18. Mother's Name (First, Middle, Maiden Surname): Alice Scaggs

19a. Informant's Name/Relationship (Type, Print): Joanna Boyer / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 E Mersey Court Baltimore Md. 21220

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro CRematory INc. Dete: 1/16/2001

20c. Location - City or Town, Stete: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 21221

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death): a. Pneumonia — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

b. Due to (or as a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and placa, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ Eldadah MD Physician

29c. License number: D0054303

29d. Date signed (Month, Day, Year): January 13, 2001

30. Name end address of person who completed cause ot death (Item 23a) (Type, Print): Dr. Eldadah 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signeture: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00548

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth C. Bauer
2. Date of Death (Month, Day, Year): January 7, 2001
3. Time of Death: 12:00 P.M.
4a. Facility Name (If not institution, give street and number): 4310 Woodlea Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-16-8563
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 24, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4310 Woodlea Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Adam M. Beck
18. Mother's Name (First, Middle, Maiden Surname): Mary Brehen

19a. Informant's Name/Relationship (Type, Print): Alice Jester- cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3900 Millner Road Baltimore, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer — Date: 1/10/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Cain — Heather Cain
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. myocardial infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Coronary artery disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffrey Cool MD
29c. License number: D0034650
29d. Date signed (Month, Day, Year): 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Jeffrey Cool 9712 Belair Rd suite #203 Baltimore, MD 21236

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00549

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred M. Bloom
2. Date of Death (Month, Day, Year): Jan. 15, 2001
3. Time of Death: 2:30 am
4a. Facility Name (If not institution, give street and number): Brightwood Center Genesis Eldercare
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-12-0853
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 17, 1904
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 506 Epsom Rd.
10f. Zip Code: 21204
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): Lawson Shields
18. Mother's Name (First, Middle, Maiden Surname): Verna

19a. Informant's Name/Relationship (Type, Print): Diane Vyskocil - Granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 Belhaven Dr., Baltimore, Md. 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Mem. Park — Date: Jan. 18, 2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: H. J. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Stroke	hours
Due to (or as a consequence of): b.	Arteriosclerotic Peripheral Vascular Disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation, Congestive Heart Failure, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D17118
29d. Date signed (Month, Day, Year): Jan 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD. 115 E. Melrose Ave 21212

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature] S Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00550

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ferne Barszcz

2. Date of Death: Month Jan. Day 14 Year 2001

3. Time of Death: 3:40 am.

4a. Facility Name (If not institution, give street and number): Long View Nursing Home

4b. City, Town, or Location of Death: Manchester

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 551-56-1147

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 12, 1919

9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2539 Old Washington Rd.

10f. Zip Code: 21157

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): Raymond Runyon

18. Mother's Name (First, Middle, Maiden Surname): Cora Wilson

19a. Informant's Name/Relationship (Type, Print): Darlene O'Mara - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2539 Old Washington Rd. Westminster, Md. 21157

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory | Date: Jan. 15, 2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: J. Garth Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chpel P.A. 3296 Charmil Dr. Manchester, Md. 21102

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimers Dementia — year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 033165

29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Steffen 2111 Hanover Pike, Hampstead MD 21074

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0196-005
B.K.S

RICHARD CARRASQUILLO

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00551

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard A. Carrasquillo
2. Date of Death Month Day Year: JAN. 12, 2001
3. Time of Death: 0452 AM
4a. Facility Name *(If not institution, give street and number)*: 83 NORTH- HARRISBURG EXPRESSWAY
4b. City, Town, or Location of Death:
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 583-63-6673
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 30 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 15, 1970
9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Pa
10b. County: York
10c. City, Town or Location: YORK
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10 Warren Rd.
10f. Zip Code: 17402
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify: Puerto Rican
14. Race - American Indian, Black, White, etc. Specify:

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: district manager
16b. Kind of Business/Industry: Papa Johns Pizza

17. Father's Name *(First, Middle, Last)*: Agapito Carrasquillo
18. Mother's Name *(First, Middle, Maiden Surname)*: Alma Acosta

19a. Informant's Name/Relationship *(Type, Print)*: Lou Ann Carrasquillo
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10 Warren Rd. York, Pa 17402

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount Cemetery
Date: Jan 16 2001
20c. Location - City or Town, State: York, Pa.

21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Head and Neck Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other *(Specify)* AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*: 1/12/01
28b. Time of Injury: UK M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Driver in auto accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: HIGHWAY
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 83 N Harrisburg Expressway

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: JAN. 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Allen Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

00-143-510
JELAMI CHEATHAM
JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a & 27 per ME G792 021401 SS

Certificate of Death

Reg. No. 2001 00552

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Jelani	Cheatham	JANUARY 09, 2001	06:17

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1☐ M 2☒ F	Yrs.	4	14			08 26 2000	M.D.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3322 1/2 Woodland Ave Apt 1A	21215	U.S.A.

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
N/A	N/A	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Victor Marshall	Michele Cheatham

19e. Informent's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Michele Chetham-Mother	3322 1/2 Woodland Ave apt 1A, Baltimore, Md 21215

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)	King Memorial Park	1/13/01	Randallstown, Md

21. Signature of Funerel Service Licensee	22. Neme and Address of Fecility
▶ Willey Edmonds	March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximele Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death)
a. SUDDEN INFANT DEATH SYNDROME

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted evenls resulting in death) Last
b.

Due to (or es e consequenca of):
c.

Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was casa referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Deeth (Check only one)
Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death
1☒ Neturel
2☐ Accident
3☐ Suicide
4☐ Homicide
5☐ Pending investigetion
6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
▶ Dennis J Chute MD	O.C.M.E.	JANUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrer's Signature
JAN 16 2001	▶ Dennis G Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00553

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola Octavia Culley

2. Date of Death (Month, Day, Year): January 11 2001

3. Time of Death: 0213

4a. Facility Name (If not institution, give street and number): Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 219-18-3222

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 5, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3416 Carriage Hill Circle Apt T1

10f. Zip Code: 21133

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Public Education

17. Father's Name (First, Middle, Last): (Unk)

18. Mother's Name (First, Middle, Maiden Surname): Helen Williams

19a. Informant's Name/Relationship (Type, Print): Shelley Ford / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133: 3416 Carriage Hill Circle Apt T1 Randallstown, MD

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc.

Date: 1/13/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: M00486

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Crowell, MD

29c. License number: D0055459

29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia Buchman Webb, MD Northwest Hospital Center

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Deputy G Banks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00554

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joann Louise Clark
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 3:55pm
4a. Facility Name *(If not institution, give street and number)*: Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-26-2364
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 18 1930
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6302 North Charles St.
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): +4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Public Health Nurse
16b. Kind of Business/Industry: Baltimore County

17. Father's Name *(First, Middle, Last)*: Elwood Hilt
18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie Irene Stein

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Allen C. Clark/ Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6302 North Charles St. Baltimore, Md. 21212

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Co.
Date: 1-13-01
20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee: Kurt J. Pauls
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COPD — 10yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
- Chronic alcohol use

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William E Randall Jr Attending Physician
29c. License number: D15808
29d. Date signed *(Month, Day, Year)*: 1-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM E. RANDALL JR MD 1205 YORK RD LUTHERVILLE MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Benjamin G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00555

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY HELEN CADWALADER

2. Date of Death Month Day Year: JANUARY 11, 2001

3. Time of Death: 11:50PM.

4a. Facility Name *(If not institution, give street and number)*: 2008 OLD JOPPA ROAD

4b. City, Town, or Location of Death: JOPPA

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 217-09-2483

6. Sex: 1☐ M XX F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12-20-1915

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: HARFORD

10c. City, Town or Location: JOPPA

10d. Inside City Limits: 1☐ Yes XX No

10e. Street and Number: 2008 OLD JOPPA ROAD

10f. Zip Code: 21085

10g. Citizen of What Country?: U.S.A.

11. Marital Status: XX 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 YEARS | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: JOURNALIST

16b. Kind of Business/Industry: LIFE MAGAZINE

17. Father's Name *(First, Middle, Last)*: THOMAS F. CADWALADER

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH M. READ

19a. Informant's Name/Relationship *(Type, Print)*: THOMAS F.CADWALADER (BROTHER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 733 COLORADO AVE.,BALTO., MD.,21210

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GREEN MOUNT CEMETERY

Date: 1-16

20c. Location - City or Town, State: BALTIMORE,MD.,21202

21. Signature of Funeral Service Licensee: ▶ R. H. Leith

22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Myocardial infarction — 2 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Arteriosclerotic coronary vascular disease — 10 years

Due to (or as a consequence of):
c. Hypertension — 30 years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1XX Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes XX No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes XX No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home XX Residence 6☐ Other *(Specify)*

27. Manner of Death: XX 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: XX 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ Phyllis K. Pullen M.D.

29c. License number: D0009620

29d. Date signed *(Month, Day, Year)*: JANUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHYLLIS PULLEN, M.D.,2807 JERUSALEM ROAD,KINGSVILLE, MD.,21087

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: ▶ Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00556

CZAKO, ALICE

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALICE G CZAKO
2. Date of Death (Month, Day, Year): January 13 2001
3. Time of Death: 4:45 A.M.
4a. Facility Name (If not institution, give street and number): NORTH Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 046-01-7485
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb-01-1914
9. Birthplace (State or Foreign Country): Bridgeport, CT

Usual Residence of Decedent

10a. State: MD
10b. County: ANNEARUNDEL
10c. City, Town or Location: DAVIDSville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3649 Patuxent River Road
10f. Zip Code: 21035
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): Joseph Pogany
18. Mother's Name (First, Middle, Maiden Surname): MARY UNKNOWN

19a. Informant's Name/Relationship (Type, Print): Albert Kondi
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3649 Patuxent RD Davidsville, MD 21035

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St John Cemetery
Date: 1-16-01
20c. Location - City or Town, State: NORWALK, CT

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stallings Funeral Home 3111 Mt RD Pasadena, MD 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CEREBROVASCULAR ACCIDENT - BRAIN STEM
Due to (or as a consequence of):
b. RENAL FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): January 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Amolen Glenn MD. 301 Hospital Drive, Glen Burnie. MD 21061.

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00557

COLE, LEROY

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leroy J. Cole

2. Date of Death Month: January Day: 13 Year: 2001

3. Time of Death: 9:00 PM

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Ann Arundel

Funeral Director

5. Social Security Number: 218-12-0241

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 10, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 7225 Crown Road

10f. Zip Code: 21060

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator

16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name *(First, Middle, Last)*: John Cole

18. Mother's Name *(First, Middle, Maiden Surname)*: Theresa Jerousek

19a. Informant's Name/Relationship *(Type, Print)*: Theresa Johnson/Granddaughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7225 Crown Rd. Glen Burnie, MD 21060

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lorraine Park Cemetery Date: Jan. 17, 2000

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: Mark Ebaugh

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 10 days

Due to (or as a consequence of):
b. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Renal Failure

Due to (or as a consequence of):
d. Gastrointestinal Bleeding

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George E. Wicks III M.D.

29c. License number: D41365

29d. Date signed *(Month, Day, Year)*: January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George E. Wicks, III M.D. 301 Hospital Drive Glen Burnie, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

8

12

01-0140-025
VANESSA CAMERON
JVW amend item 23a,27 per me G792 2/5/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00558

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VANESSA CAMERON
2. Date of Death Month Day Year: JANUARY 08, 2001
3. Time of Death: 5:50 P.M.
4a. Facility Name *(If not institution, give street and number)*: HARFORD MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: HAVRE de GRACE
4c. County of Death: HARFORD CO

Funeral Director

5. Social Security Number: 546-25-4737
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 41 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN 28, 1959
9. Birthplace *(State or Foreign Country)*: ALABAMA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD CO
10c. City, Town or Location: BELCAMP
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: P O BOX 11
10f. Zip Code: 21017-0011
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaar or Datea:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, apecify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yaa 2☒ No *Specify:*
14. Raca - American Indian, Black, White, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12yrs; College (1-4or 5+): 3yrs
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: FOOD SERVICE HANDLER
16b. Kind of Business/Industry: ABERDEEN PROVING GROUNDS

17. Fathar's Nama *(First, Middle, Last)*: WILLIE E CAMERON
18. Mothar's Nama *(First, Middle, Maidan Sumama)*: RUBY L, CAMERON

19a. Informant's Name/Relationship *(Type, Print)*: Willie E. Cameron/Father
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1518 Mitchell Ln., Aberdeen, Maryland 21001

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, crametory or othar piece)*: ST JAMES CEMETERY
Data: 01-17-01
20c. Location - City or Town, State: HAVRE DE GRACE, MD.

21. Signature of Funeral Service Licensee: Charles D. Brell
22. Nama and Addrass of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
321 S PHILADELPHIA BLVD. ABERDEEN, MD 21001

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one causa on aach lina.

Approximata Intarval Batween Onsat and Daath

Immedieta Cause (Final disaasa or condition resulting in death): a. CARDIAC ARRHYTHMIA ASSOCIATED WITH INTERSTITIAL MYOCARDIAL FIBROSIS

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last: b.

Dua to (or aa a consequence of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yas 2☐ No

24b. Ware autopsy findings available prior to completion of causa of death? 1☒ Yas 2☐ No

25. Was case rafarrad to medical examinar? 1☒ Yas 2☐ No

26. Place of Death *(Chack only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Other *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At home, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha time, data and placa, and due to tha causa(s) and mannar as stated. 2☒ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and due to the cause(s) and manner atated.

29b. Signatura and title of certifier: J. M. Tit
29c. Licansa number: O.C.M.E.
29d. Data signed *(Month, Day, Yaar)*: JANUARY 09, 2001

30. Nama and addrass of parson who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 16 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

RKD

01-0219-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

BARBARA COLLINS AMENDED ITEMS# 23a-e, ptII, 27 G792 020601 SS per M.E.

Certificate of Death

Reg. No. 2001 00559

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara Dickel Collins

2. Date of Death — Month: JANUARY Day: 13, Year: 2001

3. Time of Death: 1:58P.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL

4b. City, Town, or Location of Death: ESSEX

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-72-9334

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 44 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 2, 1956

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Perry Hall

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4111 Farmside Dr.

10f. Zip Code: 21236

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): nurse practitioner

16b. Kind of Business/Industry: medical

17. Father's Name (First, Middle, Last): Walter Howard Dickel

18. Mother's Name (First, Middle, Maiden Surname): Frances Seitz

19a. Informant's Name/Relationship (Type, Print): Ralph Collins/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4111 Farmside Dr. Perry Hall, MD 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cemetery

Date: 1/18/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John D. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA DUE TO

Due to (or as a consequence of):

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HYPER-TRIGLYCERIDEMIA DUE TO CORTICOSTERIOD USE DUE TO

Due to (or as a consequence of):

d. CHROHN'S DISEASE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature:

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00560

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frank S. Carr

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 2:00 PM

4a. Facility Name *(If not institution, give street and number)*: Manor Care Roland Park

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-14-3205

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 20, 1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 4669 Falls Road

10f. Zip Code: 21209

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Trucking

17. Father's Name *(First, Middle, Last)*: Frank S. Carr

18. Mother's Name *(First, Middle, Maiden Sumame)*: Ida Regina Gaunt

19a. Informent's Neme/Reletionship *(Type, Print)*: Roy Keene Friend

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 4669 Falls Road, Baltimore, Maryland 21209

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Druid Ridge Cemetery

Date: 1/18/01

20c. Location - City or Town, Stete: Pikesville, MD

21. Signature of Funeral Service Licensee: Lynn B. Henss

22. Neme end Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, MD 21211

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth): a. SEPSIS — Weeks

Due to (or es e consequence of):

b. WOUND INFECTION — Months

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

PARKINSONS DISEASE, ASPIRATION PNEUMONIA, MALNUTRITION, CHRONIC OBSTRUCTIVE LUNG DISEASE, HISTORY OF CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medicet examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: R Mayhew MD

29c. License number: D54285

29d. Dete signed *(Month, Day, Year)*: 15th January 2001

30. Name and addresa of parson who completed ceuse of death (Item 23a) (Type, Print): Raymond Mayhew 1445, Fungo Road, Glen Burnie MD 21060

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrer's Signature: G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00561

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FANNIE COHEN
2. Date of Death (Month, Day, Year): JANUARY 10, 2001
3. Time of Death: 2:13 PM
4a. Facility Name *(If not institution, give street and number)*: MILFORD MANOR NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-34-3045
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 97 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 9, 1903
9. Birthplace *(State or Foreign Country)*: LATVIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4204 OLD MILFORD MILL ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: IZZY SCHWARTZ
18. Mother's Name *(First, Middle, Maiden Surname)*: KAYLA (UNKNOWN)

19a. Informant's Name/Relationship *(Type, Print)*: HARRY COHEN / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1021 CHISWELL LANE - SILVER SPRING, MD 20901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FORBAND CEMETERY
Date: 1/12/01
20c. Location - City or Town, State: ROSEDALE, MD

21. Signature of Funeral Service Licensee: Jay Alan Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D37573
29d. Date signed *(Month, Day, Year)*: January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jef Zibell MD 25 Main Street Reisterstwn MD 21136

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0137-510
LRB
VERTELL DICKEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #22 PER F.H. G791 1-16-01 WR.

Certificate of Death

Reg. No. 2001 00562

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vertell Dickey
2. Date of Death (Month, Day, Year): January 08, 2001
3. Time of Death: 6:10 P.M.
4a. Facility Name (If not institution, give street and number): 401 E. 25th Street. Apt 7-B
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 216-34-6006
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01 29 38
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 401 East 25th Street
10f. Zip Code: 21218
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th grade
College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Aid
16b. Kind of Business/Industry: Nursing

17. Father's Name (First, Middle, Last): Syvester Dickey
18. Mother's Name (First, Middle, Maiden Surname): Emma Anderson

19a. Informant's Name/Relationship (Type, Print): Virginia Ferguson-Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3142 Leeds Street, Baltimore Md 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 1/15/01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Helene A. Thompson
22. Name and Address of Facility: March F/H ~~West~~ EAST 1101 E. NORTH AVE. BALTO. MD 21202 ~~4300 Wabash Ave, Baltimore Md 21215~~

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) At Scene

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Laron Locke
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Lenora G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit filed in by the funeral director.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00563

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roscoe E. DeLaulder

2. Date of Death (Month, Day, Year): Jan 12 2001

3. Time of Death: 3:00pm

4a. Facility Name (If not institution, give street and number): Genesis Eldercare - Cromwell

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-12-7687

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 5 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8300 Harris Ave.

10f. Zip Code: 21234

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Nevar Marriad 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highast grada complated): Elementary/Secondery (0-12): 12; College (1-4or 5+): —

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): plumber

16b. Kind of Business/Industry: Francis C. Dorsey Com.

17. Father's Name (First, Middle, Last): Roscoe C. DeLaulder

18. Mother's Nama (First, Middle, Maiden Sumame): Amy Lee Cooper

19a. Informant's Name/Reletionship (Type, Print): Dorothy A. DeLaulder spouse

19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code): 8300 Harris Ave. Baltimore, Md 21234

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or othar piece): Parkwood Cemetery

Data: Jan 16 2001

20c. Location - City or Town, State: Parkville, Md.

21. Signature of Funeral Service Licensee: Krista L Wells

22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Senile Dementia — Due to (or as a consequance of):

Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury thet initiated evants resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Liver Cirrhosis, Recurrent Pneumonia, Ascites, CHF, Depression,

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [✓] No

26. Placa of Daath (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Martha C Raymundo MD

29c. Licanse number: D54518

29d. Date signed (Month, Day, Year): 1/15/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Martha Raymundo 3007 E. Northern Pkway. Baltimore, Md

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signatura: Lenora B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00564

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice Drengwitz

2. Date of Death: Month January Day 13 Year 2001

3. Time of Death: 10:00PM

4a. Facility Name (If not institution, give street and number): Fairland Nursing Home & Rehabilition Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 190-05-8867

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 30 1903

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: PA.

10b. County: Cumberland

10c. City, Town or Location: Camp Hill,

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3616 Kohler Place-- Apt.3

10f. Zip Code: 17011

10g. Citizen of What Country? USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Lewis Edler

18. Mother's Name (First, Middle, Maiden Surname): Martha Cordelia Bidelspacher

19a. Informant's Name/Relationship (Type, Print): Otto L. Drengwitz-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10132 Greenuck Road, Silver Spring, Maryland20901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Jefferson Memorial Park

Date: 01/18/ 2001

20c. Location - City or Town, State: Pittsburgh,Pennsylvania

21. Signature of Funeral Service Licensee: Debra M Davis

22. Name and Address of Facility: Witzke Funeral Home of Catonsville 1630 Edmondson Ave, Catonsville, Maryland21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. Pneumonia — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. Other signifcant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings avsilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Ptaca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Andrew Kundrat

29c. License number: D36716

29d. Date signed (Month, Day, Year): January 15th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Kundrat M.D. 8217 Cherry Lane Laurel, MD. 20707

State Registrar

31. Dete filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #31 per DVR G791 011601 SS

Certificate of Death

Reg. No. 2001 00565

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
Margaret Berta DiPaola	January 14, 2001	9:30 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Future Care Nursing Home	Randallstown	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-52-2422	1☐ M 2☒ F	69 Yrs.			March 14,1931	Italy

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
8303 Mindale Circle Apt. B	21244	U.S.A.

11. Marital Status	12. Wes Decedent Evar in U.S. Armed Forcas?	13. Wes Decedant of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puerto Rican, atc.)	14. Race - Amarican Indian, Black, Whita, etc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grada completed)		16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
8		Homemaker	Own Home

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Name (First, Middle, Maiden Surnama)
Frank Arrostuto	Ida Kruger

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Vincent DiPaola (son)	8001 Glencannon Drive,Charlotte, N.C. 28227

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetary, crematory or othar place)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Lakeview Memorial Park	Jan.18, 2001	Eldersburg,Maryland

21. Signature of Funeral Service Licensee: Debra M Davis

22. Nama and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Avenue,Catonsville,Maryland 21228

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediata Cause (Final disaasa or condition resulting in death)	a. pneumonia	3 weeks
	Dua to (or as a consequance of):	
Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last	b. dysphagia	years
	Dua to (or as a consequance of):	
	c. dementia	years
	Dua to (or as a consequence of):	
	d. strokes	years

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yas 2☑ No	1☐ Yes 2☑ No

25. Was casa rafarrad to medical examiner?	26. Placa of Death (Check only one)	
1☐ Yas 2☑ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Neturel 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Date signed (Month, Day, Year)
MD	D47704	1/16/01

30. Nama and address of person who completed causa of deeth (Item 23a) (Type, Print): TRUNG PHAM M.D. 4000 old court MD 21208 Pikesville

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
1/16/01	JAN 16 2001 Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 18 per informant G792 2/2/01 yf

Certificate of Death

Reg. No. 2001 00566

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Peter Donnelly
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 7:25 PM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 017-24-4760
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 10, 1931
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 682 Ivy League Lane
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Defense

17. Father's Name (First, Middle, Last): Luke Francis Donnelly, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Rebecca McDaniels ~~Mary Rebecca McDaniel~~

19a. Informant's Name/Relationship (Type, Print): Philip G. Donnelly/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1210 Summer Sweet Lane, Mt. Airy, Maryland 21771

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: Jan. 13, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ray Lutz M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CARDIAC ARREST	-
Due to (or as a consequence of):		
b.	PULMONARY ARREST	: 6 HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of):		
c.	PROBABLE PULMONARY EMBOLISM	· 6 HOURS
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CERVICAL MYELOPATHY; WOUND DEHISCENCE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: E. F. Aulisi
29c. License number: 43921
29d. Date signed (Month, Day, Year): 1/12/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDWARD F. AULISI MD 9715 Medical Center Dr., Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DONNELLY, JOHN P. 1/10/01 TOD 1935 PM

10

DHMH 16 Rev 6/95

ORIGINAL

01-0220-003
crn
Diana Lynn Drasher

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00567

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dianna Lynn Drasher
2. Date of Death Month Dey Year: January 13, 2001
3. Time of Death: 7:11 P.M.
4e. Facility Name *(If not institution, give street and number)*: 8496 Mast Court
4b. City, Town, or Location of Death: Pasadena
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-70-3675
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 43 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 27 1957
9. Birthplace *(State or Foreign Country)*: Richmond, Va

Usual Residence of Decedent

10a. Stete: MD.
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8496 Mast Court
10f. Zip Code: 21122
10g. Citizen of Whet Country?: USa

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*
Elementery/Secondery (0-12): 12
College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nursing Assistant
16b. Kind of Business/Industry: Hospital

17. Father'e Neme *(First, Middle, Last)*: Dillard Harris
18. Mother's Name *(First, Middle, Maiden Surname)*: Louise Woelk

19e. Informent's Neme/Reletionship *(Type, Print)*: Julie Drasher (Daughter)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8496 Mast Ct. Pasadena, MD 21122

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Meadowridge Cemetery
Dete: 1/20/01
20c. Location - City or Town, State: Elkridge, MD

21. Signeture of Funeral Service Licensee: Thomas Gregor
22. Neme end Address of Facility: Stallings Funeral Home 3111 Mountain Rd. Pasadena, MD 21122

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in death):
a. Hanging
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown XX

24e. Wes en autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Deeth *(Check only one)*
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* at scene

27. Menner of Death: 1☐ Neturel 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*: Found: 01-13-2001
28b. Time of Injury: Found: 5:32 P M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject hanged herself.
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: Residence
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*: 8496 Mast Court Pasadena, Maryland

29a. Certifier *(Check only one)*
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and mennar as stated.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and mennar stated.

29b. Signeture end title of certifier:
29c. License number: O.C.M.E.
29d. Dete signed *(Month, Day, Year)*: January 14, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00568

DENNISON, CLIFFORD

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clifford Thomas Dennison, Jr.
2. Date of Death: Month JANUARY Day 11 Year 2001
3. Time of Death: 7:04 A.M.
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-40-7345
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 23, 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1708 Drexel Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Elevator Construction
16b. Kind of Business/Industry: Union

17. Father's Name (First, Middle, Last): Clifford Thomas Dennison, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Ethel Pscherer

19a. Informant's Name/Relationship (Type, Print): Mrs. Rosemary Dennison (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1708 Drexel Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: 1/15/2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. BRONCHOGENIC ADENO CARCINOMA — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, HYPERTENSION, PERIPHERAL VASCULAR DISEASE, ADDISON'S DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Babak Imanoel DO
29c. License number: BI6283472
29d. Date signed (Month, Day, Year): 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BABAK IMANOEL, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00569

DELLA CARROLL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Carroll Melson Della					2. Date of Death Month / Day / Year: JANUARY 9, 2001			3. Time of Death: 11:45AM
4e. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death: GLEN BURNIE		4c. County of Death: AA COUNTY		
5. Social Security Number: 215-07-2890	6. Sex: XX M 2☐ F	7. Age *(In yrs. last birthday)*: 81 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*: 7/25/1919		9. Birthplace *(State or Foreign Country)*: Maryland	
Usual Residence of Decedent								
10e. State: MD	10b. County: Anne Arundel	10c. City, Town or Location: Glen Burnie					10d. Inside City Limits: 1☐ Yes XX☐ No	
10e. Street and Number: 602 Old Stage Road		10f. Zip Code: 21061			10g. Citizen of What Country?: USA			
11. Marital Status: 1☐ Never Married XX☐ Married 3☐ Widowed 4☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No *Specify:*			14. Race - American Indian, Black, White, etc. *Specify:* white			
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 / College (1-4or 5+)		16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: UNK			16b. Kind of Business/Industry: UNK			
17. Father's Name *(First, Middle, Last)*: Lawrence Della					18. Mother's Name *(First, Middle, Maiden Surname)*: Lola Bruce			
19e. Informant's Name/Relationship *(Type, Print)*: Margaret M. Della - wife		19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 602 Old Stage Road, Glen Burnie, MD 21061						
20e. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*		20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Vet. Cemetery			Date: 1/12/01	20c. Location - City or Town, State: Crownsville, MD		
21. Signature of Funeral Service Licensee: Kelly Gregory Fink		22. Name and Address of Facility: FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061						

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE AND CHRONIC RESPIRATORY FAILURE	X 3 WKS
Due to (or as a consequence of):	b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	YRS.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

DIABETES MELLITUS

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
M.D.	D16445	01-09-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSE NEPOMUCENO, M.D. 7845 OAKWOOD Road #107, GLEN BURNIE, MARYLAND 21061

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
JAN 16 2001	Geneva G Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00570

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY RUTH ERICKSON
2. Date of Death Month / Day / Year: 01 / 12 / 01
3. Time of Death: 5:20 PM
4a. Facility Name *(If not institution, give street and number)*: 217 Montrose Avenue
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 181-46-4148
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 46 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 20-1954
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 217 Montrose Avenue
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12); College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Charles R. Strain
18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Farrell

19a. Informent's Neme/Reletionship *(Type, Print)*: Kenneth J. Erickson-husband
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 217 Montrose Avenue, Catonsville, Maryland 21228

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, crematory or other plece)*: Balto/Waahington Crematory
Dete: 01/17/2001
20c. Location - City or Town, State: Laurel, Maryland

21. Signeture of Funeral Service Licensee: ▶ R. Craig Witke Jr.
22. Neme end Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland 21228

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in deeth): e. CARCINOMA OF THE FALLOPIAN TUBE — 9 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as stated. 2☐ **Medicat Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted.

29b. Signature end title of certifier: ▶ [signature]
29c. License number: D0025844
29d. Date signed *(Month, Day, Year)*: 01-13-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTINE L. COMMERFORD, MD 5411 OLD FREDERICK RD BALTIMORE 21229

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 16 2001
32. Registrar's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00571

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel L. Fletcher
2. Date of Death (Month, Day, Year): Jan. 15, 2001
3. Time of Death: 5:45 P.M.
4a. Facility Name (If not institution, give street and number): Genesis Eldercare Loch Raven
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-03-1197
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/11/1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8528 Chestnut Oak Road
10f. Zip Code: 21234
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper
16b. Kind of Business/Industry: Hotel

17. Father's Name (First, Middle, Last): Thomas Fletcher
18. Mother's Name (First, Middle, Maiden Surname): Addie Danner

19a. Informant's Name/Relationship (Type, Print): Nellie Sibley Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8333 Wyton Road Towson, MD 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. | Date: 1/16/01
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: ▶ M. Neal Coleman
22. Name and Address of Facility: The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Senile Dementia	many years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HTN Leiomyosarcoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Marina C. Raymundo MD
29c. License number: D54518
29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3007 E. Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00572

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth L. Feltham
2. Data of Death — Month: January; Day: 13; Yaar: 2001
3. Tima of Death: 5:25 pm
4a. Facility Nama *(If not institution, give street and number)*: 4013 Spring Meadow Dr.
4b. City, Town, or Location of Daath: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 213-03-8237
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: April 6, 1909
9. Birthplace *(Stata or Foreign Country)*: Maryland

Usual Rasidance of Dacedant

10a. Stata: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Streel and Number: 4013 Spring Meadow Dr.
10f. Zip Coda: 21042
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puarto Ricen, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amaricen Indian, Black, White, atc. *Specify:* white

15. Decedent's Education *(Specify only highast grade compiated)*: Elamantary/Secondary (0-12): 12; Collaga (1-4or 5+):
16a. Decedant's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa ratired)*: Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fathar's Name *(First, Middla, Last)*: Adolf C. Lieder
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Anna J. Duerr

19a. Informant's Name/Ralationship *(Type, Print)*: Henry Imwold
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 6101 Medora Rd. Linthicum, Maryland 21090

20a. Mathod of Disposition: 1☐ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☒ Other *(Specify)* entombment
20b. Place of Disposition *(Name of cematary, cramatory or other place)*: Lorraine Park — Data: Jan. 17 2001
20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funaral Sarvice Licensee: [signature] Mo109L
22. Nama and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that causad tha death. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach line.

Approximata Interval Batwaen Onsat and Daath

Immadiata Cause (Final disaasa or condition resulting in daath)
a. Congestive Heart Failure — 1 year

Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseesa or injury that initiated avants rasulting in daath) Last
b.
Due to (or as a consequanca of):
c.
Dua to (or as a consequance of):
d.

Part II. **Othar significant conditions** contributing to death but not rasulting in the underlying ceuse given in Pert I.

23b. Did tobacco uaa contributa to the cauae of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of ceuse of daath? 1☐ Yas 2☐ No

25. Was cesa raferred to medical axaminar? 1☐ Yas 2☒ No

28. Plece of Death *(Chack only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☒ Residence 6☐ Othar *(Specify)*

27. Mennar of Death: 1☒ Naturel 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Yaar)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Plece of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha tima, data and plece, end due to the ceusa(s) and mannar as statad. 2☐ **Medical Examinar:** On tha basis of axaminetion end/or invastigation, in my opinion, daeth occurred at tha tima, date and plece, and due to the cause(s) and mannar statad.

29b. Signature and title of certifier: [signature]
29c. License number: D04345
29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Nama and address of person who completed ceusa of daath (Item 23a) (Type, Print): Charles E Taylor MD 2 Knoll North Drive Columbia MD 21045

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 16 2001
32. Registrar's Signatura: [signature] S Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00573

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN M FALK
2. Date of Death: Month JAN Day 11 Year 2001
3. Time of Death: 745 Am
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 172-05-2718
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 18 1915
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md.
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7795 Rockburn Dr.
10f. Zip Code: 21043
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): +4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Customer Service Representative
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): J. Oliver Fralich
18. Mother's Name (First, Middle, Maiden Surname): Mary Yeager

19a. Informant's Name/Relationship (Type, Print): Mr. Kenneth Falk / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 742 Southview Dr. Landisville, Pa. 17538

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cramatory or other place): St. Joseph Cemetery | Date: 1-15-01
20c. Location - City or Town, State: Lancaster Twp.

21. Signature of Funeral Service Licensee: Peter V. Clay
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CEREBROVASCULAR INFARCT
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE
CARDIOMYOPATHY
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D39629
29d. Data signed (Month, Day, Year): JAN 11 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALEXANDER SY MD 10724 LITTLE PATUXENT PKWY COLUMBIA MD 21044

State Registrar

31. Data filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Genevieve G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00574

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosemarie J. Greiner
2. Date of Death (Month, Day, Year): Jan. 10 2001
3. Time of Death: 8:30pm
4a. Facility Name (If not institution, give street and number): 7824 Westmoreland Ave.
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-10-3025
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 11, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7824 Westmoreland Ave.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist
16b. Kind of Business/Industry: Baltimore County Federal Employees Credit Union

17. Father's Name (First, Middle, Last): Vincent DiMaggio
18. Mother's Name (First, Middle, Maiden Surname): Mary M. Fasanella

19a. Informant's Name/Relationship (Type, Print): Linda Klingmeyer
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Killala Ct. Timonium, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery | Date: Jan 13 2001
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Kenta S. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. metastatic colon cancer	5yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Sivasailam MD
29c. License number: D45530
29d. Date signed (Month, Day, Year): January, 12th, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Sivasailam 6830 Hospital Dr. Rosedale, Md 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

AMEND ITEM: #10A PER INFORMANT G791 1-22-01 WR.
AMEND ITEM: #5 PER INFORMANT G791 1-16-01 WR.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00575

940 AM

Goodman, Daniel 1/15/01

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Daniel W. Goodman	Jan. 15, 2001	9:40 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Hospice	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-50-~~4928~~ 7928	1 X M 2 ☐ F	44 Yrs.			Dec. 28, 1956	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
~~MD~~ VA	Fairfax	Fairfax	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4119 Trowbridge St	22030	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Yeer or Dates:	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Software Engineer	GRCI Corporation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Leonard Goodman	Ruth Ellen Teplitz

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruth E. Goodman / mother	3906 Hadley Square West Baltimore, MD 21218

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Chesapeake Crematory, Inc	1/17/01	Beltsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Laura C. Hardesty	CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finai disease or condition resulting in death)	a. glioblastoma multiforme	15 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1 ☐ Yas 2 X No	1 ☐ Yes 2 ☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medicel examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Othar (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Piece of Injury - At home, farm, street, fectory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) end manner as stated.
2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, daath occurred at the time, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
W. Anthony Riley, MD	D25205	January 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WP

DHMH 16 Rev 6/95

ORIGINAL

EDWARD GORWELL 11/5/2001 TOD 6:05AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00576

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Treulieb Gorwell

2. Date of Death Month: 01 Day: 15 Year: 2001

3. Time of Death: 6:05AM

4a. Facility Name *(If not institution, give street and number)*: 522 East 35th Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-42-4524

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 23, 1944

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residance of Dacedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 522 East 35th Street

10f. Zip Coda: 21218

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Naver Married 2☐Merried 3☐Widowed 4☒Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☒Yas 2☐No If Yes, Give Year or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Plumber / Electrician

16b. Kind of Business/Industry: Construction

17. Fathar's Nama *(First, Middle, Last)*: William Ludwig Gorwell

18. Mothar's Name *(First, Middle, Maiden Surname)*: Mary Lee Treulieb

19a. Informant's Name/Relationship *(Type, Print)*: Mary Lee Gorwell / mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 522 East 35th Street., Baltimore, MD 21218

20a. Mathod of Disposition: 1☐Burial 2☒Cramation 3☐Ramovel from Stata 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory, Inc.

Date: 1/16/01

20c. Location - City or Town, Stata: Beltsville, MD

21. Signeture of Funarel Service Licensee: Laura C Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disaesa, or complicetions thet caused the daeth. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximate Interval Batween Onset and Death

Immediata Causa (Final disaase or condition resulting in death)

a. Glioblastoma

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

b. Seizures

Dua to (or as a consequance of):

c.

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yas 2☑No

24b. Ware autopsy findings available prior to complation of cause of death? 1☐Yes 2☐No

25. Wes casa rafarred to medical examinar? 1☐Yas 2☐No

26. Place of Daath *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Home 5☑Residence 8☐Othar *(Specify)*

27. Mannar of Death: 1☐Natural 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, street, factory, office buiiding, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: Michael A Randolph MD

29c. Licansa number: D34680

29d. Data signed *(Month, Day, Year)*: January 15, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Michael A Randolph MD 3333 North Calvert St #655 Baltimore Md 21218

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signatura: Jeanne G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

UG x1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00577

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Griffiths
2. Date of Death — Month: January Day: 12 Year: 2001
3. Time of Death: 0854
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 090-10-8015
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04-03-1911
9. Birthplace (State or Foreign Country): TEXAS

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1606 CLIFTON AVE
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CORRECTIONS OFFICIER
16b. Kind of Business/Industry: PENAL SYSTEM

17. Father's Name (First, Middle, Last): REGENALD GRIFFITHS
18. Mother's Name (First, Middle, Maiden Surname): REBECCA RADLER

19a. Informant's Name/Relationship (Type, Print): BESSIE GEIFFITHS, WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1606 CLIFTON AVE, BALTO. MD 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST
Date: 1-18-01
20c. Location - City or Town, State: OWING MILLS, MD

21. Signature of Funeral Service Licensee: Willie E Howell Jr.
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Septic shock	3 days
Due to (or as a consequence of): b.	heart failure	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: RES-000
29d. Date signed (Month, Day, Year): January 14 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANEESH SHARMA 600 North Wolfe St Baltimore, MD 21287-9106

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #20C PER F.H. G791 1-16-01 WR.

Certificate of Death

Reg. No. 2001 00578

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERNEST GIBSON
2. Date of Death (Month, Day, Year): JANUARY 13, 2001
3. Time of Death: 8:10AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-10-5999
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11 09 14
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 27 South Ellamont Street
10f. Zip Code: 21229
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6th grade
College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Bethlehem Steel Corp

17. Father's Name (First, Middle, Last): Ernest R. Gibson
18. Mother's Name (First, Middle, Maiden Surname): Lucy Stokes

19a. Informant's Name/Relationship (Type, Print): Evelyn Gilson-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 South Ellamont Street, Baltimore Md 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland National Ceme.
Date: 1/17/01
20c. Location - City or Town, State: LAUREL, MD ~~Laurel, Md~~
21. Signature of Funeral Service Licensee: Dale March
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Acute MI
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature end title of certifier: MD
29c. License number: D44505
29d. Date signed (Month, Day, Year): January 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.J. IMPERIAL, JR. MD — NWHR.

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00579

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carol S. Grothe

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 8:05 PM

4a. Facility Name *(If not institution, give street and number)*: Montgomery Village Care and Rehabilitation

4b. City, Town, or Location of Death: Montgomery Village

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 481-36-6497

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 1, 1934

9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 142 Bent Twig Lane

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Ross Paschall

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Beardsley

19a. Informant's Name/Relationship *(Type, Print)*: Leo A. Grothe / Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11629 Pleasant Meadow Drive, Gaithersburg, Maryland 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.

Date: January 15, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 1 WEEK.

Due to (or as a consequence of):

b. CENTRAL PONTINE MYELINOSIS — 2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ALCOHOLIC CIRRHOSIS — UNKNOWN

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0055200

29d. Date signed *(Month, Day, Year)*: January 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANGEETHA MURTHY 19504 DOCTORS DRIVE GERMANTOWN MD 20874

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature:

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or there 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00580

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen S. Gerstmyer

2. Date of Death Month Day Year: 01 14 2001

3. Time of Death: 5:55am

4a. Facility Name (If not institution, give street and number): Maryland Masonic HOmes

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-10-6390

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05/18/1918

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: COCKEYSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 300 INTERNATIONAL CIRCLE

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): WILLIAM SCHLEUNING

18. Mother's Name (First, Middle, Maiden Surname): VIRGINIA MORGAN

19a. Informant's Name/Relationship (Type, Print): NEWELL GERSTMYER(HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 INTERNATIONAL CIRCLE COCKEYSVILLE,MD 21030.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEM.

Date: 01/17/2001

20c. Location - City or Town, State: TIMONIUM,MD.

21. Signature of Funeral Service Licensee: ▶ William R. Lewis III

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe Dementia

Due to (or as a consequence of):

b. Multple Infarct

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ASVD

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's, Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ R. Liberto, MD.

29c. License number: D21464

29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT LIBERTO, MD, 3508 Bank St BALTO, Md 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: ▶ Jessica G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00581

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: TIMOTHY GARCIA GARDNER

2. Date of Death Month / Day / Year: January 10, 2001

3. Time of Death: 1:24 PM

4a. Facility Name *(If not Institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-88-4460

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 36 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 23, 1964

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 4265 Ethlona Ave

10f. Zip Code: 21207

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Baltimore City

17. Father's Name *(First, Middle, Last)*: Elmore Gardner, JR

18. Mother's Name *(First, Middle, Maiden Surname)*: Beverly Ann

19a. Informant's Name/Relationship *(Type, Print)*: Elmore Gardner, JR. / father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3721 Washington Ave Baltimore, Md 21244

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion Cemetery

Date: 1-15-2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jeroy Harris

22. Name and Address of Facility: CHATMAN-HARRIS FUNERAL HOME 5240 Reisterstown Road Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Obesity - Hypoventilation Syndrome

Due to (or as a consequence of):

b. Acute Bronchitis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcus McKenzie, MD 2401 West Belvedere Avenue Baltimore, Maryland 21215

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Jennie G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Patient known as Timothy Gardner

5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00582

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wesley Thomas Grahn

2. Date of Death Month Day Year: JANUARY 11, 2001

3. Time of Death: 2:35 AM

4e. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-28-7858

8. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 6,1930

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☐No XX

10e. Street and Number: 276 S. Monastary Avenue

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1XXNever Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2XXNo Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12); College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: Relocation Specialist

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Wesley Hugo Grahn

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes McGrail

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Molly Queralt (Sister)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11501 Web Chapel Road Dallas,Texas 75229

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5XXOther *(Specify)* Entombment

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Green Mount Cemetery

Date: 1/13/01

20c. Location - City or Town, State: Baltimore,Maryland

21. Signature of Funeral Service Licensee: ▶ Steven T. Bittle

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore,Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CHRONIC LYMPHOCYTIC LEUKEMIA

END-STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D30263

29d. Date signed *(Month, Day, Year)*: 1-12-01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00583

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Amelia May Gover
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 4:24am
4a. Facility Name (If not institution, give street and number): Longview Nursing Home
4b. City, Town, or Location of Death: Manchester
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-20-1494
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 100 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 17, 1900
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Phoenix
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2810 Paper Mill Road
10f. Zip Code: 21131
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Franklin Barrett
18. Mother's Name (First, Middle, Maiden Surname): Amelia May Wilhelm

19a. Informant's Name/Relationship (Type, Print): Marjorie G. Harmon/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2806 Paper Mill Road, Phoenix, MD 21131

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Poplar Grove Cemetery
Date: 01/15/01
20c. Location - City or Town, State: Phoenix, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's Dementia — year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: mr
29c. License number: D33165
29d. Date signed (Month, Day, Year): January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven N. Shaffer, MD 2111 Hanover Pike, Hampstead, MD 21074

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00584

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): REUBEN GOLDSTEIN
2. Date of Death: Month JAN Day 11 Year 01
3. Time of Death: 02:40 AM
4a. Facility Name (If not institution, give street and number): ER UPPER CHESAPEAKE MED CTR
4b. City, Town, or Location of Death: BEL AIR
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 213-03-8098
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 24, 1918
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: HARFORD
10c. City, Town or Location: EDGEWOOD
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 801 FISHERMAN LANE
10f. Zip Code: 21040
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII ARMY
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DRIVER
16b. Kind of Business/Industry: TRUCKING

17. Father's Name (First, Middle, Last): JOSEPH GOLDSTEIN
18. Mother's Neme (First, Middle, Maiden Sumame): ETHEL MEISTER

19a. Informant's Neme/Relationship (Type, Print): MARGARET GOLDSTEIN / WIFE
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 801 FISHERMAN LANE - EDGEWOOD, MD 21040

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): JWV MD FREE STATE POST 167
Date: 1/12/01
20c. Location - City or Town, State: ROSEDALE, MD

21. Signature of Funeral Service Licensee: Michael Bruce
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in death)
a. ASCUD
Due to (or es a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASBESTOSIS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: DME
29c. License number: OCME
29d. Date signed (Month, Day, Year): JAN 11 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G PRABHU MD 728 BELAIR RD BEL AIR MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00585

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLEN HURLEY
2. Date of Death: Month JANUARY Day 12 Year 2001
3. Time of Death: 9:50 AM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 215-32-1637
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-28-1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1 Mopec Circle Apt. 1D
10f. Zip Code: 21236
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 7th grade; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Wire Cutter
16b. Kind of Business/Industry: Bendix

17. Father's Name (First, Middle, Last): William Hurley
18. Mother's Neme (First, Middle, Meiden Surneme): Olivia Keyser

19a. Informent's Neme/Reletionship (Type, Print): Robert G. Hurley (Brother)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7007 Linden Avenue Baltimore, Md. 21206

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Parkwood Cemetery
Date: 1-15-2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: E. F. Lassahn
22. Name end Address of Facility: Lassahn Funeral Home, 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. SEPSIS — 2 DAYS
Due to (or as a consequence of):
b. MESENTERIC ISCHEMIA
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RHABDOMYOLYSIS
ANOXIC ENCEPHALOPATHY
HYPOTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: MD
29c. License number: P12557
29d. Date signed (Month, Day, Year): JANUARY 12, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): RAPHAEL DODOO, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To be Completed by Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00586

Hoes, William

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM HOES
2. Date of Death (Month, Day, Year): January 8, 2001
3. Time of Death: 12:17pm
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-28-3869
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV. 27, 1931
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: BALTIMORE
10c. City, Town or Location: DUNDALK
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6610 WOODS PARKWAY
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ASSEMBLY LINE WORKER
16b. Kind of Business/Industry: BETHLEHEMSTEEL CORPORATION

17. Father's Name *(First, Middle, Last)*: WILLIAM JEFF HOES
18. Mother's Name *(First, Middle, Maiden Surname)*: MARGARITE CRUMP

19a. Informant's Name/Relationship *(Type, Print)*: JEAN BROWN-SISTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1600 MT. ROYAL AVE. BALTIMORE, MD.

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METRO CREMATORY
Date: 1/16/01
20c. Location - City or Town, State: CATONSVILLE, MD.

21. Signature of Funeral Service Licensee: Lewis T. Gwynn LEWIS T. GWYNN
22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — 6-9 months
Due to (or as a consequence of):
b. Tobacco Abuse — 35 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Bushra Alazzawi MD
29c. License number: 203380
29d. Date signed *(Month, Day, Year)*: 1/8/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bushra Alazzawi MD. 9000 Franklin Square Hospital Drive Baltimore Maryland 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva G Jones

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00587

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Hursey, Sr.

2. Date of Death — Month: Jan; Day: 10; Year: 2001

3. Time of Death: 3:30pm

4a. Facility Name *(If not institution, give street and number)*: 56 Neptune Ct.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-36-8197

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: April 9, 1940

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 56 Neptune Ct.

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 10th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use Retired)*: Water Proofer

16b. Kind of Business/Industry: Water Co.

17. Father's Name *(First, Middle, Last)*: Jacob Dyson

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Hursey

19a. Informant's Name/Relationship *(Type, Print)*: Linda Hursey - X-wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4203 Stanwood Ave. Balto., MD. 21206

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: Jan. 13, 2001

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Gary P. March Funeral Home, P.A. 270 Fredhilton Pass Balto., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. INFECTED PACEMAKER

Due to (or as a consequence of):

b. SICK SINUS SYNDROME

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)* — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Maharaj M.D.

29c. License number: P 13457

29d. Date signed *(Month, Day, Year)*: JANUARY 12th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROSEMARIE MARAJ C/O GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALT MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: ▶ [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00588

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PRISCILLA LYDIA HOFMANN
2. Date of Death Month Day Year: January 13, 2001
3. Time of Death: 1:00 AM
4a. Facility Name *(If not institution, give street and number)*: Pickersgill, Inc.
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-38-4406
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 99 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 25, 1901
9. Birthplace *(State or Foreign Country)*: USA

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 615 Chestnut Ave.
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: High School

17. Father's Name *(First, Middle, Last)*: George Washington Hofmann
18. Mother's Name *(First, Middle, Maiden Surname)*: Elvina Zewald

19a. Informant's Name/Relationship *(Type, Print)*: Pickersgill, Inc./care giver
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 615 Chestnut Ave. Towson, Md. 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery
Date: 01/16/01
20c. Location - City or Town, State: Parkville, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ischemic cardiomyopathy — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Baltimore, Md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

01-0174-510
mnmr
James Hunter -El
amend item 23a,27,28a,b,c,d,e,f per me G791 1/18/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00589

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES J. HUNTER-EL

2. Date of Death: Month: January Day: 11, Year: 2001

3. Time of Death: 308 am

4a. Facility Name (If not institution, give street and number): 5102 Denview Way

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-60-8522

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 2, 1952

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5100 DENVIEW WAY APT #G

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 8th

College (1-4or 5+): NA

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: ROOFING

17. Father's Name (First, Middle, Last): JAMES HUNTER

18. Mother's Name (First, Middle, Maiden Surname): DORIS ELIZABETH HUNTER

19a. Informant's Name/Relationship (Type, Print): CYNTHIA B. HUNTER-EL (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5100 DENVIEW WAY #G BALTIMORW, MD 21206

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK

Date: 1/16/01

20c. Location - City or Town, State: RANDALLSTOWN.MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: WYLIE FUNERAL HOME PA
638 N. GILMOR STREET, BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HANGING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 1/11/2001

28b. Time of Injury: unknown M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): parking lot

28f. Location (Street and Number or Rural Route Number, City or Town, State): 5102 Denview Way, Baltimore, Md

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00590

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANITA HARRIS
2. Date of Death Month: JANUARY Day: 14 Year: 2001
3. Time of Death: 5:35 PM
4a. Facility Name (If not institution, give street and number): Northwest Hospital
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-18-6032
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-25-09
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 2815 Remington Avenue
10f. Zip Code: 21211
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retail
16b. Kind of Business/Industry: Huzler's Towson

17. Father's Name (First, Middle, Last): Alfred Harris
18. Mother's Neme (First, Middle, Maiden Surname): Matilda Gray

19a. Informant's Neme/Reletionship (Type, Print): Bertha M. Chase
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3669 Forest Hill Road Baltimore, Maryland 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Pleca ot Disposition (Neme of cemetery, cremetory or other piece): Pleasant Rest Cemetery
Date: 01-18-01
20c. Location - City or Town, Stete: Towson, MD

21. Signature of Funeral Service Licensee: ▶ G Lodge Wanes
22. Name and Address ot Fecility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart teilure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequenca of):
b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as e consequenca ot):
c. HYPERLIPIDEMIA

Due to (or as e consequenca ot):
d.

Part It. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete ot Injury (Month, Dey Yeer): 1/14/01
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece ot Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ Joseph N Kwanyuo MD
29c. License number: D30309
29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH AWANDAK NKWANYUO, 3100 TIMANUS LANE SUITE 108, BALTIMORE 21244

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00591

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE HORAK
2. Date of Death: Month JAN Day 10 Year 2001
3. Time of Death: 11 10 AM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 212 01 6217
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 02. 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore CITY
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: XX [X] Yes 2 [ ] No
10e. Street and Number: 4218 HAMILTON AVENUE
10f. Zip Code: 21206
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mailman
16b. Kind of Business/Industry: U. S. Postal Service

17. Father's Name (First, Middle, Last): Frank Horak
18. Mother's Name (First, Middle, Maiden Surname): Barbara Sevec

19a. Informant's Name/Relationship (Type, Print): Terry Leipold (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4218 Hamilton Avenue Baltimore, Md. 21206

20a. Method of Disposition: XX [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cem. Date: 1-13-01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: E. J. Lassahn
22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. HYPOTENSION	30 MINUTES
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. ACUTE MYOCARDIAL INFARCTION	5 DAYS
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rene M.D
29c. License number: P14420
29d. Date signed (Month, Day, Year): JAN 10 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Regina B. OSIH MD. GOOD SAMARITAN HOSPITAL, BALTIMORE MD

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Wg+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00592

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BEATRICE Luther CARMICHAEL HAMER
2. Date of Death (Month, Day, Year): January 11 2001
3. Time of Death: 1026
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 215 22 5459
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 22, 1915
9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3100 ELBERT Street
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Engineer
16b. Kind of Business/Industry: Private family

17. Father's Name (First, Middle, Last): Luther CARMICHAEL
18. Mother's Name (First, Middle, Maiden Surname): Mary Bise

19a. Informant's Name/Relationship (Type, Print): Rose Dawn / niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3100 Elbert Street Baltimore, Md 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park — Date: 1/16/01
20c. Location - City or Town, State: Arbutus, Maryland
21. Signature of Funeral Service Licensee: Gary Harris
22. Name and Address of Facility: Chatman-Hankin Funeral Home, 5240 Reisterstown Road, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Coronary Artery Disease — 45 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D0027315
29d. Date signed (Month, Day, Year): January 11, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M.L. Fruhenberg MD St. Agnes Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00593

ETHEL HERBIG

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ethel Herbig
2. Date of Death Month / Day / Year: January 12th 2001
3. Time of Death: 5:37A
4a. Facility Name *(If not institution, give street and number)*: Millenium Health And Rehabilitation
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Ann Arundel.

Funeral Director

5. Social Security Number: 213-03-0618
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 9, 1906
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10e. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 224 Carvel Road
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Household

17. Father's Name *(First, Middle, Last)*: Harry W. Sargen
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Irene R. Nagle

19e. Interment's Neme/Reletionship *(Type, Print)*: Janet M. Burl - Daughter
19b. Melling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 224 Carvel Road, Pasadena, MD 21122

20e. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Metro Crematory
Dete: Jan.16
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

Physician /Medical Examiner

23a. Part1. Enter the diseese or complications that cesused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

		Approximete Interval Between Onset end Deeth
Immediate Ceuse (Final diseese or condition resulting in death) a.	Brain Stem Cerebrovascular Accident.	1 week.
Due to (or es e consequenca of): b.		
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest — Due to (or as a consequenca of): c.		
Due to (or es e consequence of): d.		

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrilation, Diabetes, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: [signature] Attending Physician
29c. License number: D44973
29d. Date signed *(Month, Dey, Year)*: Jan 12th 2001

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): GURMEET-S SAWHNEY MD 325 HOSPITAL DRIVE 202 GLENBURNIE MD 21061

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00594

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT L. HURT
2. Date of Death — Month: January Day: 12 Year: 2001
3. Time of Death: 6:05 AM
4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 412-50-5436
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 67 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 4, 1933
9. Birthplace *(State or Foreign Country)*: TENNESSEE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 902 SHAMROCK CT.
10f. Zip Code: 21060
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: KOREAN CONFLICT
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ENGINEER
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name *(First, Middle, Last)*: GEORGE L. HURT
18. Mother's Name *(First, Middle, Maiden Surname)*: ETTA M. VAUGHAN

19a. Informant's Name/Relationship *(Type, Print)*: KATHERINE A. DUNN / DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4925 COLUMBIA RD., APT. C., COLUMBIA, MD 21044

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MEADOWRIDGE MEM. PARK — Date: JAN. 16 2001
20c. Location - City or Town, State: ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Renal Failure — 24 Hrs

Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Gastrointestinal Bleeding

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George E. Wicks III M.D.
29c. License number: D41365
29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George E. Wicks III M.D. 301 Hospital Drive, Glen Burnie, MD. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

HURT, ROBERT

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00595

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CAILIN HERBERT
2. Date of Death Month / Day / Year: JAN 14 2001
3. Time of Death: 07:39AM
4a. Facility Name *(If not institution, give street and number)*: ER UPPER CHESAPEAKE MED CTR
4b. City, Town, or Location of Death: BELAIR
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 212-38-1997
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 18, 1939
9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford Co.
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 601 Fox Bow Drive
10f. Zip Code: 21014
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Director of Intergrated Care Management
16b. Kind of Business/Industry: St. Joseph Medical Center

17. Fether's Neme *(First, Middle, Last)*: Gerald Francis Ryan
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Mary Elizabeth Steil

19a. Informent's Neme/Reletionship *(Type, Print)*: Mr. Ronald M. Herbert, Sr./Husband
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 601 Fox Bow Drive Bel Air, Maryland 21014

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☒ Other *(Specify)* Entombment
20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: Bel Air Mem. Gardens
Date: 1/18/2001
20c. Location - City or Town, Stete: Bel Air, Maryland

21. Signeture of Funerel Service Licensee: ▶ Michael C. Carnaggio
22. Neme end Address of Facility: 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line. — Approximate Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death): a. A-S-CV-D

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: HYPERTENSION

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medicel examiner? 1☒ Yes 2☐ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: ▶ DME
29c. License number: OCME
29d. Date signed *(Month, Dey, Year)*: JAN 14 2001

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): GS PRABHU M.D 728 BELAIR ND BELAIR MD 21014

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 16 2001
32. Registrer's Signeture: ▶ Jeanne G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00596

HANAUER, LEONIE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1. Decedent's Name (First, Middle, Last): LEONIE MARY HANAUER		2. Date of Death: Month January Day 11 Year 2001	3. Time of Death: 07:17 PM
4a. Facility Name (If not institution, give street and number): Sinai Hospital	4b. City, Town, or Location of Death: Baltimore	4c. County of Death: N/A	
5. Social Security Number: 220-09-6841	6. Sex: 1☐ M 2☒ F	7. Age (In yrs. last birthday): 96 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR.5,1904	9. Birthplace (State or Foreign Country): GERMANY		

Usual Residence of Decedent

10a. State: MD	10b. County: N/A	10c. City, Town or Location: BALTIMORE	10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 2211 W. ROGERS AVENUE	10f. Zip Code: 21209	10g. Citizen of What Country?: U.S.A.	
11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE	16b. Kind of Business/Industry: OWN HOME	
17. Father's Name (First, Middle, Last): JAKOB LEOPOLD MAYER	18. Mother's Name (First, Middle, Maiden Surname): SELMA MARX		
19a. Informant's Name/Relationship (Type, Print): HARRY KULP / FRIEND	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3037 COLLIER ROAD - RANDALLSTOWN, MD 21133		
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place): CHEVRA AHAVAS CHESED	Date: 1/12/01	20c. Location - City or Town, State: RANDALLSTOWN, MD
21. Signature of Funeral Service Licensee: Jay Allan Levinson	22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	5 Days
Due to (or as a consequence of):	b. Myocardial Infarction	4 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Respiratory Failure	3 Days
Due to (or as a consequence of):	d. Congestive Heart Failure	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number: RES 000	29d. Date signed (Month, Day, Year): Jannary 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SONG-CHU KO, M.D. Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001	32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00597

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maria Hane

2. Date of Death (Month, Day, Year): January 9, 2001

3. Time of Death: 0645

4a. Facility Name (If not institution, give street and number): Future Care of the Chesapeake

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 090-38-3102

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6/15/1910

9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 305 College Parkway

10f. Zip Code: 21012

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Karl Dort

18. Mother's Name (First, Middle, Maiden Surname): Helena Kaiser

19a. Informant's Name/Relationship (Type, Print): Herbert Hane - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 779 Stinchcomb Road, Severna Park, MD 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Cemetery | Date: 1/12/01

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Kelly Gregory Fink

22. Name and Address of Facility: FINK FUNERAL HOME, PA, 426 Crain Hwy., SW, Glen Burnie, MD 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Atrial fibrillation

Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Mahoney MD

29c. License number: D-40521

29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. O'HANLEY 7845 Oakwood Road Suite 205 Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0085-510
mnmr
Fitzhugh Johnson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00598

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Fitzhugh L. Johnson
2. Date of Death Month Day Year: January 05, 2001
3. Time of Death: 1602 pm
4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 239-58-0636
8. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 04 26 39
9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4004 Garrison Blvd 2nd Floor
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes [XX] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*
Elementery/Secondery (0-12): 11th grade
College (1-4or 5+): na
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Unemployed
16b. Kind of Business/Industry: Unemployed

17. Father's Name *(First, Middle, Last)*: Fitzhugh L. Johnson Sr.
18. Mother's Name *(First, Middle, Meiden Surname)*: Mattie Newkirk

19a. Informant's Name/Relationship *(Type, Print)*: Easter Lilly Johnson-Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4408 Main Ave, Baltimore Md 21207

20a. Method of Disposition: [XX] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Memorial Park
Date: 1/13/01
20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Harry L. Thomas
22. Name and Address of Facility: March F/H West
4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASTHMA - CHRONIC ALCOHOLISM

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? PENDING 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*
Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wayne McCall
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 06, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. Stephanos D. Kolon
111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

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ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00599

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Charles	Pelton	Johnson	01	07	2001	8:15a.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Nursing Home	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-40-7015	1[X] M 2[ ] F	58 Yrs.			10 06 42	M.D.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1716 McHenry Street 1st Floor	21223	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Reca - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[X] Divorced	1[ ] Yes 2[X] No If Yes, Give Yeer or Dates:	1[ ] Yes 2[X] No Specify: A	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupation (Give kind of work done dunng most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th grade	na	House Keeping	University Hosp.

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Anthony Johnson	Corrine Jackson

19a. Informant's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ebony Johnson-Daughter	3 Silerton Road Apt 3B, Arbutus, Md 21227

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removel from State 4[ ] Donation 5[ ] Other (Specify)	Mt. Calvary Cemetery	1/13/01	Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.

22. Neme and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dytng, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Intervel Between Onset and Deeth
Immediete Cause (Finet disease or condition resulting in deeth)	a. Laryngeal Cancer	9 months
	Due to (or es a consequenca of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1[X] Yes 2[ ] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was cese referred to medical examiner?	26. Ptece of Death (Check only one)	
1[ ] Yes 2[X] No	Hospitel: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) Hospice

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1[X] Netural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigetion 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1[X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as stated. 2[ ] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) and menner steted.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
W. Anthony Riley MD	D25225	January 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signeture
JAN 16 2001	Lenora G Sparks

ORIGINAL

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Johnson January 7, 2001 e 815A

Charles

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00600

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marianne S. Keebs
2. Date of Death (Month, Day, Year): JANUARY 12, 2001
3. Time of Death: 11:26 AM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-28-4186
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 26, 1930
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7811 Clacksworth Place
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: OWNER
16b. Kind of Business/Industry: Premier Refridgeration

17. Father's Name *(First, Middle, Last)*: William Schwaezel
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Odea

19a. Informant's Name/Relationship *(Type, Print)*: Edward J. Keebs
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7811 Clacksworth Place Baltimore Md 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery | Date: Jan 16 2001
20c. Location - City or Town, State: Parkville, Md.

21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. INTRACRANIAL HEMORRHAGE	1 DAY
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: METASTATIC CARCINOMA OF BREAST

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Francis Khoo
29c. License number: D 30263
29d. Date signed *(Month, Day, Year)*: 1-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00601

KANZLER, Alice

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Alice Norine Kanzler
2. Date of Death: Month JANUARY Day 13 Year 2001
3. Time of Death: 5:10 AM
4a. Facility Name (If not institution, give street and number): St. Elizabeth Rehab and Nursing Ctr
4b. City, Town, or Location of Death: Baltimore, MD
4c. County of Death:
5. Social Security Number: 212-20-6072
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 11, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 30 Haddington Road
10f. Zip Code: 21093
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Book Keeper
16b. Kind of Business/Industry: American Lung Assoc.
17. Father's Name (First, Middle, Last): Henry Dittmar, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Katharine Georges
19a. Informant's Name/Relationship (Type, Print): David Kanzler / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2088 Misty Meadow Rd., Finksburg, MD 21048
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc
Date: 1/16/01
20c. Location - City or Town, State: Beltsville, MD
21. Signature of Funeral Service Licensee: ▶ [signature] M00986
22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Multi organ failure	days
Due to (or as a consequence of): b.	Sepsis	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Pneumonia	weeks
Due to (or as a consequence of): d.	Dysphagia	months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cardiomyopathy, Coronary artery Disease, Cerebrovascular Accident, Diabetes Type 2

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ F.M. Glotty, MD

29c. License number: D33320

29d. Date signed (Month, Day, Year): 1/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): F. M. Glotty III, MD 3320 Benson Ave Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: ▶ [signature] D Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00602

Kreidler, Melvin
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin D. Kreidler
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 8:15AM
4e. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-01-3191
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/21/1915
9. Birthplace (State or Foreign Country): Ironville, PA

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: White Marsh
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5301 Forge Road
10f. Zip Code: 21162
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 Years
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Drop Hammer Operator
16b. Kind of Business/Industry: Martin CO.

17. Father's Name (First, Middle, Last): Arthur Kreidler
18. Mother's Name (First, Middle, Maiden Surname): Alverta Derstler

19a. Informant's Name/Relationship (Type, Print): Joan Weitzel (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5301 Forge Rd. White Marsh, MD 21162

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens
Date: 1/15/01
20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: E.F. Lassahn
22. Name and Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Rd Kingsville, MD 21087

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia — 6 Days
Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Yvonne Latimer MD
29c. License number: 20347 1
29d. Date signed (Month, Day, Year): 1/11/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Yvonne Latimer MD 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Donna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0242-510

JOSEPH KAIRYS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a,b,ptII,27,& 28a-f per ME G792 01801 38

Certificate of Death

Reg. No. 2001 00603

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH ROBERT KAIRYS, SR.

2. Date of Death Month Day Year: JANUARY 14, 2001

3. Time of Death: 10:33A.M.

4a Facility Name (If not institution, give street and number): UNIVERSITY HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 218-15-1105

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 24 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 14, 1977

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 19 MARLEY NECK ROAD

10f. Zip Code: 21060

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1995-1996

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DRIVER

16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name (First, Middle, Last): THOMAS G. SCONES

18. Mother's Name (First, Middle, Meiden Sumeme): SHARON LARKINS

19e. Informant's Name/Relationship (Type, Print): APRIL KAIRYS / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19 MARLEY NECK ROAD GLEN BURNIE, MD 21060

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): GLEN HAVEN MEM. PARK Date: JAN. 18, 2000

20c. Location - City or Town, State: GLEN BURNIE,MD

21. Signature of Funeral Service Licensee: Lou L Ebaugh

22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEPATIC NECROSIS AND FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. ACETAMINOPHEN INTOXICATION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Naturat 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Dey Year): 1-8-01

28b. Time of Injury: P M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 191-11 Adamsville Rd Greenwood, Delaware

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and menner as stated. 2 [X] Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J M. T

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 15,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 16 2001

32. Registrar's Signature: Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00604

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN FAWCETT KNIPP

2. Date of Death (Month – Day – Year): 01 – 11 – 2001

3. Time of Death: 2:55 Am

4a. Facility Name (If not institution, give street and number): Edenwald

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-20-9096

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 28, 1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 800 Southerly Rd.

10f. Zip Code: 21286

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): journalist

16b. Kind of Business/Industry: newspaper

17. Father's Name (First, Middle, Last): John Fawcett

18. Mother's Name (First, Middle, Maiden Surname): Anne Rouche

19a. Informant's Name/Relationship (Type, Print): Anne Knipp Griffith/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3113 Guilford Ave. Baltimore, MD 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 1/16/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George Brennan

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure — 5 yrs

Due to (or as a consequence of):

b. Chronic obstructive pulmonary disease — 5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Atherosclerotic disease — 5 yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marcelino D. Alvarez Jr. physician

29c. License number: D29769

29d. Data signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Marcelino D. Alvarez Jr. MD 516 N. Rolling Rd Bal MD

State Registrar

31. Data filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Barbara B Spencer

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00605

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Fotini KYRIAKAKOS
2. Date of Death: Month January Day 15 Year 2001
3. Time of Death: 11:10am
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-58-5236
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 9, 1934
9. Birthplace (State or Foreign Country): Greece

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1404 Falls Crest Drive
10f. Zip Code: 21047
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Elias Kapetanakos
18. Mother's Name (First, Middle, Maiden Surname): Georgia Poliemanakos

19a. Informant's Name/Relationship (Type, Print): Athanasia Diakokomninos/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1404 Falls Crest Drive Fallston Maryland 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Demetrios Cemetery
Date: 01/18/01
20c. Location - City or Town, State: Cub Hill Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton
Christina L. Hilton
22. Name and Address of Facility: Leonard J. Ruck, Inc.
5305 Harford Road Baltimore Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC Breast CANCER

Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: P 13453
29d. Date signed (Month, Day, Year): January 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GONZALO GIANELLA MD. 4004 Raven Blvd #5601. BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Jeanne G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00606

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR THOMAS KAHLER

2. Date of Death Month Day Year: January 7, 2001

3. Time of Death: 4:30 PM

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-03-3813

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 17, 1915

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: PASADENA

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1231 HILLCREEK ROAD

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MACHINIST

16b. Kind of Business/Industry: KOPPERS COMPANY

17. Father's Name *(First, Middle, Last)*: OLIVER WILLIAM KAHLER

18. Mother's Name *(First, Middle, Maiden Surname)*: EDNA ELISE CLUBB

19a. Informant's Name/Relationship *(Type, Print)*: OLIVER WILLIAM KAHLER (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 504 DORCHESTER RD., BALTIMORE, MD 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LOUDON PARK CEMETERY

Date: 1/12/01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: LOUDON PARK FUNERAL HOME 3620 WILKENS AVE., BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE S/P CORONARY ARTERY BYPASS SURGERY

H/O Lung Cancer

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 51245

29d. Date signed *(Month, Day, Year)*: January 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAJID SHARIF NORTH ARUNDEL HOSPITAL- Hospital Drive - GLEN BURNIE, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Penny G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Kahler Arthur T.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00607

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Lee Hawkins

2. Date of Death Month Day Year: 01 09 2001

3. Time of Death: 7:25p.m.

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Nursing Home

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 244-07-0810

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10 16 13

9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3404 Flannery Lane

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th grade; College (1-4or 5+): na

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Form Setter

16b. Kind of Business/Industry: Construction Co.

17. Father's Name *(First, Middle, Last)*: Fred Hawkins

18. Mother's Name *(First, Middle, Maiden Surname)*: Hattie Brook

19a. Informant's Name/Relationship *(Type, Print)*: Doris Hawkins-Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3404 Flannery Lane, Baltimore Md 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery

Date: 1/15/01

20c. Location - City or Town, State: Baltimore Co, Md

21. Signature of Funeral Service Licensee: Harry L. Young Jr.

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. persistent vegetative state — 2 weeks

Due to (or as a consequence of):

b. Hypoglycemic encephalopathy — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Anthony Riley, MD

29c. License number: D25205

29d. Data signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Barbara G. Jones

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1/9/01 2:35 pm Hawkins, Robert

NO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00608

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GRACE ROBERTS LORENZ

2. Date of Death (Month, Day, Year): January 10 2001

3. Time of Death: 1905

4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: -

Funeral Director

5. Social Security Number: 213-28-5769

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 12, 1907

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 8800 WALTHER BLVD # 1311

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: FOOD SERVICE

17. Father's Name (First, Middle, Last): JOHN F. QUINN

18. Mother's Name (First, Middle, Maiden Surname): ROSE K. KNAPP

19a. Informant's Name/Relationship (Type, Print): LYNN R. JEAN, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 GRAY SQUIRREL CT. TIMONIUM, MD. 21093

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): EVANS FUNERAL CHAPEL BELAIR - P.A.

Date: JAN. 12, 2001

20c. Location - City or Town, State: FOREST HILL, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EVANS FUNERAL CHAPEL 8800 HARFORD RD. PARKVILLE, MD. 21234

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart failure — 1 mn

Due to (or as a consequence of):

b. Hypertension — 10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Cardiomyopathy — 5 yrs

Due to (or as a consequence of):

d. CVA — 20 mn

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: P14387

29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen G. Garrison, 201 E. University Parkway, Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00609

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GARY L. LEE
2. Date of Death — Month: JANUARY Day: 9 Year: 2001
3. Time of Death: 8:57PM
4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-62-1557
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09/02/1953
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1213 LIGHT ST.
10f. Zip Code: 21201
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12YRS — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER
16b. Kind of Business/Industry: TRUCKING

17. Father's Name *(First, Middle, Last)*: JOSEPH E. LEE
18. Mother's Name *(First, Middle, Maiden Surname)*: EARLENE G. COOPER

19a. Informant's Name/Relationship *(Type, Print)*: LINDA K. LEE(WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3046 MATHEWS ST. BALTO.,MD. 21218.

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GREEN MOUNT CREMATORY — Date: 01/11/2001
20c. Location - City or Town, State: BALTO.,MD.

21. Signature of Funeral Service Licensee: William R. Lewis III
22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. EPIDURAL HEMATOMA — TWO DAYS

Due to (or as a consequence of):
b. SEIZURE DISORDERS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOL ABUSE

PANCREATITIS.

ORGANIC BRAIN DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sumeet Sawhney MD
29c. License number: P. 14121
29d. Date signed *(Month, Day, Year)*: JANUARY 9 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUMEET SAWHNEY, HARBOR HOSPITAL CENTER.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00610

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIAN M. LOWREY

2. Date of Death: Month JAN. Day 11 Year 2001

3. Time of Death: 2:05PM

4a. Facility Name *(If not institution, give street and number)*: GILCHRIST CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-48-4367

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 13, 1911

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium- Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 216 Deer Fox Lane

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 8 yrs.

College (1-4or 5+): N/A

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Homemaking-Own Home

17. Father's Name *(First, Middle, Last)*: Samuel Stanley

18. Mother's Name *(First, Middle, Maiden Surname)*: Molly Englebright

19a. Informant's Name/Relationship *(Type, Print)*: Somers L. Huether

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 216 Deer Fox Lane Timonium, Md. 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 1-15-2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ E. T. Lassahn

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Rectal cancer - recurrent

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Advanced age, cardiovascular disease

23b. **Did tobacco uas contributs to the causs of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ E. T. Souweine MD

29c. License number: 024732

29d. Date signed *(Month, Day, Year)*: 1/12/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): E. T. Souweine MD 21 West Rd. Towson, Md. 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: ▶ Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

January 11, 2001 2:05 pm

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00611

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EMMA EISELE LAFFERTY
2. Date of Death: Month January Day 15 Year 2001
3. Time of Death: 11:50 AM
4a. Facility Name (If not institution, give street and number): Keswick Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-46-1122
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 101 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 25, 1899
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 700 W. 40th. Street
10f. Zip Code: 21211
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 4 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Gustav Frederick Eisele
18. Mother's Name (First, Middle, Maiden Surname): Anna Klopfer

19a. Informent's Name/Relationship (Type, Print): Frederick W. Lafferty (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1956 S. Ocean Lane Fort Lauderdale, Florida 33316

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Dete: 1-17-01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George J. Fennane
22. Name end Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on each line. (Approximete Intervel Between Onset end Deeth)

Immediate Cause (Final disease or condition resulting in death): a. Advanced atherosclerotic cardiovascular disease unknown
Due to (or es a consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due lo (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rheumatoid arthritis with chronic anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: M. Isabelle Mae Gregor M.D.
29c. License number: D13657
29d. Date signed (Month, Day, Year): January 15, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): M. ISABELLE MACGREGOR, KESWICK, 700 W. 40TH STREET, BALTIMORE, MD 21211

State Registrar

31. Dete filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Jessie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00612

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: TERESA M LETSO

2. Date of Death *(Month, Day, Year)*: JAN 12 2001

3. Time of Death: 7:45am

4a. Facility Name *(If not Institution, give street and number)*: 115 Lariat Road

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-30-0834

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 3 1932

9. Birthplace *(State or Foreign Country)*: MAryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 115 Lariat Road

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: August Bitter

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Cambell

19a. Informant's Name/Relationship *(Type, Print)*: George Letso / husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 115 Lariat Road Baltimore MD 21220

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc

Date: 1/13/01

20c. Location - City or Town, State: Balitmore MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, auch as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death) a. End Stage Pulmanary disease — 6-8 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Ischemic Cardiamyopathy, HTN.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD.

29c. License number: D-38754

29d. Date signed *(Month, Day, Year)*: 01-12-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MALIKA WASSEM. 709. EASTERN BLVD. MD - 21221.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: ▶ Jeanne G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00613

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth LAVIX

2. Date of Death: Month JANUARY Day 11 Year 2001

3. Time of Death: 8:54 AM

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 187-12-6623

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 10, 1923

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1945 Denbury Drive

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Clerical

17. Father's Name (First, Middle, Last): Earl Howells

18. Mother's Name (First, Middle, Maiden Surname): Meda Fedderhoff

19a. Informant's Name/Relationship (Type, Print): Mr. Paul A. Lavix (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1945 Denbury Drive Dundalk, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 1/12/2001

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Small cell lung Cancer — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Brain metastases

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], M.D.

29c. License number: D54911

29d. Date signed (Month, Day, Year): 01-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rodrigo B. Erlich - 4940 Eastern Ave. Baltimore MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00614

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Virginia Carroll Lee

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 9:47p

4a. Facility Name *(If not institution, give street and number)*: Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-22-3164

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 30 1926

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 10200 Daventry Drive

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): n/a

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Banking

17. Father's Name *(First, Middle, Last)*: Joseph Whitney Gooding

18. Mother's Name *(First, Middle, Maiden Surname)*: Marguerite Jane Unknown by informant

19a. Informant's Name/Relationship *(Type, Print)*: Thomas John Carroll, Jr./Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 150 Viscaya Ave., Royal Palm Beach, FL 33411

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Memorial Gardens

Date: 1/16/01

20c. Location - City or Town, State: Timonium, MD 21093

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Adult Respiratory Distress Syndrome — one week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Multiple myeloma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marshall A. Levine, M.D.

29c. License number: D17873

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marshall A. Levine 6569 North Charles St Baltimore, Maryland 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Lee, Virginia

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00615

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruby Arlene Lange

2. Date of Death — Month: Jan. Day: 13 Year: 2001

3. Time of Death: 8:05 am.

4a. Facility Name *(If not institution, give street and number)*: Westminster Nursing Home

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-38-8740

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 20, 1909

9. Birthplace *(State or Foreign Country)*: Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 617 East Deep Run Rd.

10f. Zip Code: 21158

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name *(First, Middle, Last)*: Dwight L. Hollingsworth

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Walburn

19a. Informant's Name/Relationship *(Type, Print)*: Julius D. Lange - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 607 East Deep Run Rd. Westminster, Md. 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadow Ridge Mem. Park — Date: Jan. 16, 2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ J. Garth Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, Md. 21102

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	1wk
	Due to (or as a consequence of): LUPUS	10yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): ASCVD	25y
	c. Due to (or as a consequence of): Lung Cancer	6y
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John Middleton

29c. License number: D25443

29d. Date signed *(Month, Day, Year)*: 1-13-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 698 Poole Rd, Westminster Md 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: ▶ [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00616

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SARAH LEVIN

2. Date of Death: Month JANUARY Day 8 Year 2001

3. Time of Death: 8:08 PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-01-6261

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 8, 1917

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7920 SCOTTS LEVEL ROAD

10f. Zip Code: 21208

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATIVE ASSISTANT

16b. Kind of Business/Industry: NAVAL INTELLIGENCE

17. Father's Name (First, Middle, Last): ABRAHAM LEVIN

18. Mother's Name (First, Middle, Maiden Surname): BESSIE LANE

19a. Informant's Name/Relationship (Type, Print): DAVID LEVIN / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3402 TULSA ROAD - BALTIMORE, MD 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): BALTIMORE HEBREW CEMETERY

Date: 1/12/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Michael Bruce

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final diseese or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: CLIFFORD FABER MD

29c. License number: 024970

29d. Data signed (Month, Day, Year): JANUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CLIFFORD FABER, MD 5401 OLD COURT ROAD, RANDALLSTOWN, MARYLAND 21133

State Registrar

31. Data filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00617

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julia Maskal
2. Data of Death Month Day Year: Jan 11 2001
3. Time of Death: 12:00pm
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-16-6826
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Yaer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Aug 14 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Rasidance of Decedant

10a. Stete: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 8711 Edgefield Rd.
10f. Zip Code: 21234
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Educetion (Specify only highast grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): Sales
16b. Kind of Businass/Industry: J.C. Penney

17. Fether's Name (First, Middle, Last): Steve Szabo
18. Mothar's Name (First, Middle, Maiden Surnema): Julia Kocsis

19a. Informent's Neme/Relationship (Type, Print): Nancy Cruz
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8711 Edgefield Rd. Baltimore, Md 21234

20a. Method of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Removal from Stete 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Name of cematary, crametory or other place): Sacred Heart of Jesus
Data: Jan 15 2001
20c. Location - City or Town, State: Dundalk Md
21. Signature of Funeral Servica Licensee: Krista L Udelle
22. Nama and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Entar tha disaase, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory errest, shock, or haart failura. List only ona causa on aach lina. — Approximate Intarval Between Onset and Death

Immedieta Causa (Final diseasa or condition rasulting in daath): e. Bacterial Pnuemonia
Dua to (or as a consequance of):
Sequantially list conditions, if any, leading to immadiate ceusa. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in daath) Last:
b. Dua to (or as a consequance of):
c. Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings availeble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cesa rafarred to medicel examiner? 1☐ Yas 2☒ No
26. Plece of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Residence 6☒ Othar (Specify) HOSPICE

27. Mennar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined
28a. Deta of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred at the time, date and piece, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigetion, in my opinion, daath occurred at tha time, date and place, and dua to the cause(s) and mannar stated.

29b. Signeture and titla of certifiar: TAM=
29c. Licansa number: D43725
29d. Date signed (Month, Dey, Year): 1/12/01

30. Name and address of person who complated ceuse of deeth (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Data filed (Month, Day, Year): JAN 16 2001
32. Registrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

JANUARY 11, 2001 12:00 p.m.

JULIA MOSKAL

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#3 perDVRG791 1/16/2001 EW

Certificate of Death

Reg. No. 2001 00618

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vernon Joseph Miller

2. Date of Death: Month January Day 13, 2001 Year

3. Time of Death: 1 PM.

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-16-3344

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 5, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Overlea

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 308 Dale Ave

10f. Zip Code: 21206

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): Joseph Miller

18. Mother's Name (First, Middle, Maiden Surname): Clara Shipley

19a. Informant's Name/Relationship (Type, Print): Ulia C. Miller / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 308 Vale Ave., Overlea, MD 21200

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake, Crematory, Inc.

Date: 1/16/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepatocellular Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Stella Maris at Mercy

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [✓] Other (Specify) Hospice

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] M

29c. License number: D40854

29d. Date signed (Month, Day, Year): January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore MD 21202

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00619

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean T. Mullins
2. Date of Death Month: JANUARY Day: 9 Year: 2001
3. Time of Death: 9:30 AM
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 129-28-8472
6. Sex: 1☐ M 2☑ F
7. Age (In yrs., last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 25, 1932
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2908 Manhattan Ave.
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): unk.
18. Mother's Name (First, Middle, Maiden Surname): unk.

19a. Informant's Name/Relationship (Type, Print): Pamela Brown - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2908 Manhattan Ave. Balto., MD. 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 1-16-01
20c. Location - City or Town, State: Lansdowne, MD.

21. Signature of Funeral Service Licensee: Gary P. March
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 270 Fredrick Pass Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE LUNG DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as a consequence of):
c. HYPOTHYROIDISM

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: WARREN J. SMITH MD
29c. License number: D24148
29d. Date signed (Month, Day, Year): JAN. 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WARREN SMITH MD 3502 W. ROGERS AVE #6 BALTO MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours aftar death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as tha burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 5 per fh G792 2/13/01 yf

Certificate of Death

Reg. No. 2001 00620

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LORRAINE MC FADDEN
2. Date of Death: Month JANUARY Day 11, Year 2001
3. Time of Death: 536 AM
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: none

Funeral Director

5. Social Security Number: ~~216-66-5701~~ ~~238-96-3733~~
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 07, 1956
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: none
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1513 Mullikin Court
10f. Zip Code: 21231
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Afro American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: OWN Home

17. Father's Name (First, Middle, Last): JAMES MC FADDEN
18. Mother's Name (First, Middle, Maiden Surname): Ruby Holloway MC FADDEN

19a. Informant's Name/Relationship (Type, Print): Clarissa B. Christian
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1513 Mullikin Court - Baltimore, Maryland 21231

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 1/16/01
20c. Location - City or Town, State: Lansdowne, Maryland

21. Signature of Funeral Service Licensee: Nancy M. Wallace
22. Name and Address of Facility: Nancy M. Wallace Funeral Service, 3405 W. Franklin St. Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metabolic Acidosis
Due to (or as a consequence of):
b. End Stage Renal Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. Severe Sepsis
Due to (or as a consequence of):
d. Hypotension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Exploratory Laparotomy
Small Bowel Obstruction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: ~~T~~ 14581
29d. Date signed (Month, Day, Year): 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GOVIND MUKUNDAN, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva S Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Lorraine McFadden

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00621

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MOSES MURPHY
2. Date of Death Month / Day / Year: JANUARY 11 2001
3. Time of Death: 21:51
4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS BAYVIEW
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-01-9162
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 13, 1910
9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 707 N. LAKEWOOD AVENUE
10f. Zip Code: 21205
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unk | College (1-4or 5+): unk
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MERCHANT SEAMAN
16b. Kind of Business/Industry: SHIP

17. Father's Name *(First, Middle, Last)*: BLOUNT MURPHY
18. Mother's Name *(First, Middle, Maiden Surname)*: PRISCILLA HAWKINS

19a. Informant's Name/Relationship *(Type, Print)*: LIZZIE LINTON (GUARDIAN)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 34 MARKET PLACE SUITE 304 BALTIMORE, MD 21202

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. ZION CEMTERY
Date: 1/15/01
20c. Location - City or Town, State: LANSDOWNE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: RES-000
29d. Date signed *(Month, Day, Year)*: JANUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AUDREY LIU 4940 EASTERN AVENUE BALTIMORE, MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00622

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine A. Mohr

2. Date of Death: Month: January Day: 12 Year: 2001

3. Time of Death: 0425

4a. Facility Name (If not institution, give street and number): Upper Chesapeak Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-14-0610

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8/3/1914

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Kingsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11618 Mohr Road

10f. Zip Code: 21087

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 years; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Martin Co.

17. Father's Name (First, Middle, Last): William Mohr

18. Mother's Name (First, Middle, Maiden Surname): Mary Ann Cassidy

19a. Informant's Name/Relationship (Type, Print): Robert Panzer(Guardian)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2953 Burnley Court Abingdon, Md 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 1/15/2001

20c. Location - City or Town, State: Baltimore County, MD

21. Signature of Funeral Service Licensee: E. F. Lassahn

22. Name and Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Rd Kingsville, Md 21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hyporemia	1 hour
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Myocardial Infarction	2 hours
	Due to (or as a consequence of):	
	c. Ventricular Tachycardia	2 hours
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypokalemia

Gastroenteritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D53462

29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jude Moneses 2845 Oakwood Road Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

MOHR, CATHERINE

DHMH 16 Rev 6/95

ORIGINAL

01-175-510
LARRY MOORE
JVW

amend item 23a,27 per me G791 1/23/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00623

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Larry Moore
2. Date of Death (Month, Day, Year): JANUARY 11, 2001
3. Time of Death: 05:47 A.M.
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-74-7218
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-08-60
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2702 Jefferson Street
10f. Zip Code: 21205
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade | College (1-4or 5+): NA
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: various trades

17. Father's Name (First, Middle, Last): Moses Moore
18. Mother's Name (First, Middle, Maiden Surname): Annie Ragin

19a. Informant's Name/Relationship (Type, Print): Annie Moore
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 527 N. Washington Street Baltimore, MD 21205

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Voshell Mem. Gardens
Dete: 01-16-2000
20c. Location - City or Town, State: Dundalk, MD

21. Signeture of Funeral Service Licensee: [signature]
22. Name end Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or haart failure. List only one cause on aech lina.

Approximate Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. DIABETIC KETOACIDOSIS

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To tha best of my knowladga, death occurred at the time, data and place, and due to tha causa(s) and mannar as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and mennar stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 11, 2001

30. Name and address of person who completed causa of death (Item 23e) (Type, Print): J LAWON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00624

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES W. MILLER
2. Date of Death: Month Jan, Day 13, Year 2001
3. Time of Death: 0740
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 215-22-1716
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months, Days; If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept, 24, 1927
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7240 Fairbrook Raod
10f. Zip Code: 21244
10g. Citizen of What Country: USA

11. Meritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Yeer or Detes: 1946 1947
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify: X
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 9; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Self-employed
16b. Kind of Business/Industry: Maintenance

17. Father's Name (First, Middle, Last): James Lafayette Miller
18. Mother's Neme (First, Middle, Maiden Surname): Minnie May Miller

19a. Informent's Neme/Reletionship (Type, Print): Eleanor Miller- wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7240 Fairbrook Road, Woodlawn, Maryland 21244

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other piece): Lake View Memorial Park — Dete: 01/17/2001
20c. Location - City or Town, Stete: Eldersburg, Maryland

21. Signeture of Funeral Service Licensee: Bernard Dalrymple
22. Name end Address of Fecility: Witzkes Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland 21228

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. — Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death):
a. Sepsis
Due to (or es e consequence of):
b. Diverticulitis
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last
Due to (or es e consequence of):
c. COPD
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
IAN GINA PECTORIS
DIABETES MELLITUS
Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Deeth (Check only one): Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Deeth: 1 ☐ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, etreet, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner es stated. 2 ☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner etated.

29b. Signeture and title of certifier: Joseph C. Mar — M.D. RESIDENT
29c. License number: P11707
29d. Date signed (Month, Day, Year): January 13, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Joseph C. Mar — 900 CATON AVE, ST. AGNES HOSPITAL, BALTIMORE MD 21229

State Registrar

31. Dete filed (Month, Day, Year): JAN 16 2001
32. Registrer's Signeture: Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

NAME MILLER, CHARLES W.
Division of Vital Records, P.O. Box 68760,

6+1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00625

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ida A. Mandato
2. Date of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 5:38pm
4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 055-03-5358
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 21,1909
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2251 Mt. Hebron Drive
10f. Zip Code: 21042
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Nicola Sanzo
18. Mother's Neme *(First, Middle, Maiden Surname)*: Addolorata Diorio

19a. Informant's Name/Relationship *(Type, Print)*: Joan Lambertson (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2251 Mt.Hebron Drive,Ellicott City,Maryland 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery
Date: Jan.18, 2001
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: ▶ Valorie McClain
22. Name and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Avenue,Catonsville,Maryland 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaese or condition resulting in death)
a. Inanition — few days

Due to (or as a consequence of):
b. Alzheimer's Dementia — several years

Sequenfially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Gastrointestinal bleeding

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the tima, date and piece, and due to the cause(s) and mannar statad.

29b. Signatura and fitla of certifier: ▶ Geetha Raja MD
29c. Licensa number: D27541
29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): GEETHA RAJA, 4367 Holline Ferry Rd, Baltimore MD-21227

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00626

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Angela Mahon
2. Date of Death (Month, Day, Year): January 13, 2001
3. Time of Death: 2:20 PM
4a. Facility Name (If not institution, give street and number): All Saints Convent-1501 Hilton Avenue
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 115-05-7885
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 25, 1905
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 1501 Hilton Avenue
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): Unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Episcopal Nun
16b. Kind of Business/Industry: Church

17. Father's Name (First, Middle, Last): Aylett Clifton Mahon
18. Mother's Name (First, Middle, Maiden Surname): Williametta Louise Wilson

19a. Informant's Name/Relationship (Type, Print): Mother Catherine Grace-friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1501 Hilton Avenue, Catonsville, Maryland21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): All Saints Convent Cemetery
Date: 01/16/2001
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Debra McDavis
22. Name and Address of Facility: Witzke Funeral Home, Inc
1630 Edmondson Avenue, Catonsville, Maryland21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic obstructive pulmonary disease — 10 yrs
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Hospice

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Payne MD
29c. License number: D13012
29d. Date signed (Month, Day, Year): 14 Jan 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W Payne MD 1565 N. Charles St 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JANUARY 13, 2001 2:20 PM
SISTER RUTH ANGELA MAHON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00627

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUIS D Miller
2. Date of Death Month: JAN Day: 13 Year: 01
3. Time of Death: 0908
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 215-09-5918
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 6 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 5036 Bonnie Branch Rd.
10f. Zip Code: 21043
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Amoco Oil Co.
17. Father's Name (First, Middle, Last): George Miller
18. Mother's Name (First, Middle, Maiden Surname): Lucille Dorsam
19a. Informant's Name/Relationship (Type, Print): Kriss Miller / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5036 Bonnie Branch Rd. Ellicott City, MD. 21043
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Cemetery
Date: Jan. 19 2001
20c. Location - City or Town, State: Elkridge, Maryland
21. Signature of Funeral Service Licensee: [signature] Mo1094
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial infarction — hours

Due to (or as a consequence of):
b. Congestive heart failure — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ischemic cardiomyopathy — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D500776
29d. Date signed (Month, Day, Year): JAN 14 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN H. EVERSLEY M.D 4801 Dorsey Hall Drive EllicottCity

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00628

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDITH MILLIGAN

2. Date of Death — Month: JANUARY Day: 15 Year: 2001

3. Time of Death: 0220 hrs.

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL 5601 Loch Raven Blvd.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-20-5858

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 15, 1925

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4700 HARFORD ROAD

10f. Zip Code: 21214

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th grade — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE AID

16b. Kind of Business/Industry: HEALTH CARE

17. Father's Name (First, Middle, Last): ROBERT MILLIGAN

18. Mother's Name (First, Middle, Maiden Surname): ELLA MILLIGAN

19a. Informant's Name/Relationship (Type, Print): Dorothea L. Moore/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1513 Northwood Dr., Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND NATL CEMETERY

Date: 1-19-01

20c. Location - City or Town, State: LAUREL, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SYSTEMIC INFLAMMATORY RESPONCE SYNDROME

Due to (or as a consequence of):
b. RENAL FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ATRIAL FIBRILLATION

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ratna Nair RESIDENT PGY2

29c. License number: P13965

29d. Date signed (Month, Day, Year): JANUARY 15TH 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RATNA NAIR GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00629

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARC Allen McABEE
2. Date of Death Month: JAN Day: 10 Year: 2001
3. Time of Death: 0710
4a. Facility Name (If not institution, give street and number): #10 11th Ave., N.W
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: AA

Funeral Director

5. Social Security Number: 220-80-3210
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 2, 1962
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10 11th Ave.
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Water & Fire Restoration
16b. Kind of Business/Industry: Building & Maintenance

17. Father's Name (First, Middle, Last): Harold P. McAbee
18. Mother's Name (First, Middle, Maiden Surname): Patricia Kelly

19a. Informant's Name/Relationship (Type, Print): Jean E. McAbee / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 11th Ave., Glen Burnie, Maryland 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem. Park
Date: Jan. 13 2001
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Asphyxia
Due to (or as a consequence of):
b. Hanging
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Autoerotic Mechanism
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 1/10/01
28b. Time of Injury: UNK M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Hung Self
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): Glen Burnie, MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William P. Jones Deputy MD
29c. License number: D060054
29d. Date signed (Month, Day, Year): 1/10/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 6695 America 21035

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #5 PER F.H. G7911 1-25-01 WR.

Certificate of Death

Reg. No. 2001 00630

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD E. McCASLIN
2. Date of Death (Month, Day, Year): January 13, 2001
3. Time of Death: 6:20AM
4a. Facility Name (If not institution, give street and number): Glen Meadows
4b. City, Town, or Location of Death: Glen Arm
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: ~~188-18-4424~~ 218-18-4424
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 30, 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Glen Arm
10d. Inside City Limits: 1 ☐ Yes 2 XX No
10e. Street and Number: 11630 Glen Arm Road
10f. Zip Code: 21057
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes XX ☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Principal
16b. Kind of Business/Industry: Balto County Board of Ed.

17. Father's Name (First, Middle, Last): Wilbur J. McCaslin
18. Mother's Name (First, Middle, Maiden Surname): Barbara Hutchinson

19a. Informant's Name/Relationship (Type, Print): Edna J McCaslin Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11630 Glen Arm Road Glen Arm, Maryland 21057

20a. Method of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Bee Tree Cemetery — Date: 1/16/01
20c. Location - City or Town, State: Parkton, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenakos
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failura. List only one cause on eech lina.

		Approximata Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. SENILE DEMENTIA OF THE ALZHEIMER'S TYPE	~5 yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ✓ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ✓ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ✓ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M Daly MD
29c. License number: D 30433
29d. Data signed (Month, Day, Year): 1/15/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M DALY c/o GBMC 6701 N CHARLES STREET BALTIMORE MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00631

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Edward P. McDermott III	January 9, 2001	7:52PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-22-3430	1☒ M 2☐ F	73 Yrs.			Oct. 16 1927	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Worcester	Berlin	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
177 Windjammer Rd.	21811	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elemantary/Secondary (0-12)	College (1-4or 5+)		
	+7	Sales	Payroll

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Edward P. McDermott, Jr.	Ann Miller

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda)
Mrs. Mary Ann Hoster/ Dtr.	30221 Southampton Bridge Rd. Salisbury, Md. 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hilltop Service Co.	1-15-01	Towson, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kit J. Pough	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onsat and Death
Immediate Cause (Final disease or condition resulting in death)	a. Leiomyosarcoma of Stomach	5 years
	Due to (or as a consaquence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequance of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Place of Death (Check only ona)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datermined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowladge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A. Anthony Riley, MD	D25205	January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	▶ Jeanne G Sparks

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00632

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara Price Coleman Merrick
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 2052
4a. Facility Name (If not institution, give street and number): Upper Chesapeake Health Center
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-40-0318
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 10, 2001
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Jarrettsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3643 Fox Meadow Court
10f. Zip Code: 21084
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur Maylon Price
18. Mother's Name (First, Middle, Maiden Surname): Katherine Schrivner

19a. Informant's Name/Relationship (Type, Print): Charles K. Merrick/husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3643 Fox Meadow Court Jarrettsville, MD 21084

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Friends Meeting House Cem. | Date: 01/13/2001
20c. Location - City or Town, State: Sparks, MD

21. Signature of Funeral Service Licensee: Stephen D. Coster M01122
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	2 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: MRSA sepsis.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signature end title of certifier
29c. License number: D37612
29d. Date signed (Month, Day, Year): 1/10/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): M. Alabrash, MD. 1201 Agora Drive, 2C, Bel Air MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Merrick, Barbara, Pri

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00633

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CENZI T MASTEL

2. Date of Death Month / Day / Year: JAN 12 2001

3. Time of Death: 1:55PM

4a. Facility Name *(If not institution, give street and number)*: GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-32-2061

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 18,1914

9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 914 Rappaix Court

10f. Zip Code: 21286

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 yr's / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Sears

17. Father's Name *(First, Middle, Last)*: George Kaffl

18. Mother's Name *(First, Middle, Maiden Surname)*: Creszenz Niggl

19a. Informant's Name/Relationship *(Type, Print)*: Diane Reddy - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 914 Rappaix Court Towson, MD 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp. Date: 1/13/01

20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: ▶ Paul L. Hartsock Jr

22. Name and Address of Facility: Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 HArford Rd.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Intracerebral bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☑ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Neeraj Verma MD

29c. License number: P14412

29d. Date signed *(Month, Day, Year)*: JAN 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5601 LOCH RAVEN BLVD GOOD SAMARITAN HOSPITAL BALTIMORE MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#19b perINFG791 1/19/2001 EW

Certificate of Death

Reg. No. 2001 00634

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Matthews
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 9:20 PM
4a. Facility Name (If not institution, give street and number): 2306 Central Avenue
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-26-6175
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 10, 1913
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2306 Central Avenue
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bottler
16b. Kind of Business/Industry: Seagrams Plant

17. Father's Name (First, Middle, Last): Alexander Anoweck
18. Mother's Name (First, Middle, Maiden Surname): Mary Trubus

19a. Informant's Name/Relationship (Type, Print): (Son) Mr. Thomas Matthews, Sr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~7506~~ 7500 Cypress Ave. Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery | Date: 1/15/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ D. C. Canell
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CARDIAC ARRHYTHMIA	DAYS
Due to (or as a consequence of): b.	ARTERIOSCLEROTIC HEART DISEASE	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEGENERATIVE JOINT DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ B.C. Veneracion Jr MD DPA
29c. License number: D 13664
29d. Date signed (Month, Day, Year): January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. C. VENERACION JR MD, 1576 MERRITT BLVD, BALTO, MD 21222

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00635

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PRESTON MULLINEAUX

2. Date of Death: Month 1 Day 12 Year 2001

3. Time of Death: 10:30 AM

4a. Facility Name (If not institution, give street and number): Cherrywood Healthcare and Rehabilitation Ctr.

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-14-6817

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Aug. 14, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5945 Oakland Road

10f. Zip Code: 21784

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 ☐ Yas 2 ☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4or 5+): -0-

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Walter Preston Mullineaux

18. Mother's Name (First, Middle, Meiden Surname): Marie Bourghman

19a. Informant's Name/Relationship (Type, Print): Thomas P. Mullineaux - Son

19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11968 Simpsons Mill Road; Keymar, Maryland 21757

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Lake View Memorial Park | Date: 1/15/01

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licansee: ▶ [signature] M00869

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Daath

Immediata Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. COR-pulmonale

Due to (or as a consequenca of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying causa givan in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1 ☒ **Yes** 2 ☐ No 3 ☐ **Probably** 4 ☐ **Unknown**

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ T. Kawaja

29c. License number: D25112

29d. Date signed (Month, Day, Year): 1/12/2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): TAHOORA KAWAJA 20, Crossroads Dr. Suite 101 Owings Mills MD 21117

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signatura: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00636

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: **John Garland McCauley, Jr.**

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 9:49 PM

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 216-28-4526

6. Sex: 1 ☐ M 2 ☐ F (X)

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 9, 1932

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 718 Hollow Road

10f. Zip Code: 21043

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married (X) 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes (X) 2 ☐ No
If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No (X) *Specify:*

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Special Police Officer

16b. Kind of Business/Industry: security

17. Father's Name *(First, Middle, Last)*: John Garland McCauley

18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Blanche Minor

19a. Informant's Name/Relationship *(Type, Print)*: Mrs Alice E. McCauley

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 718 Hollow Road Ellicott City, Maryland 21043

20a. Method of Disposition: 1 ☐ Burial (X) 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Good Shepherd Cemetery

Date: 01/17/01

20c. Location - City or Town, State: Ellicott City, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. atherosclerotic coronary artery disease

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*
Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death
1 ☑ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Jeannine Saunders MD

29c. License number: D33061

29d. Date signed *(Month, Day, Year)*: January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeannine Saunders St Agnes Healthcare Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

McCauley, John G.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00637

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Sarah T. Mitchell
2. Dete of Deeth (Month, Dey, Year): January 14 2001
3. Time of Death: 3:30 AM
4e. Facility Neme *(If not Institution, give street end number)*: Heritage Nursing Center
4b. City, Town, or Location of Death: Dundalk
4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 219-18-3772
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 23 1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2716 Dumbrook Court
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S. of America

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 5 | College (1-4or 5+): NA
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Clerk
16b. Kind of Business/Industry: Department Store

17. Father's Neme *(First, Middle, Last)*: Tierins Campelli
18. Mother's Neme *(First, Middle, Maiden Surname)*: Clementina Matana

19a. Informent's Neme/Reletionship *(Type, Print)*: Edward Robert Mitchell (Son)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2105 Dundalk Ave. Dundalk, Maryland 21222

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Metro | Dete: January 16,2001
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: Mark A. Dąbrowski
22. Neme end Address of Feciility: W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such ee cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finel diseese or condition resulting in deeth) e.	Cerebrovascular Accident	6 weeks
Due to (or as e consequence of):	Essential Hypertension	15 years
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest b.		
Due to (or es e consequence of): c.		
Due to (or es e consequence of): d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uae contributa to the cauae of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and manner steted.
29b. Signeture end title of certifier: Harjit Singh M.D.
29c. License number: D0014160
29d. Dete signed *(Month, Day, Year)*: 01/15/01
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrer's Signeture: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00638

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID BENJAMIN MILLER

2. Date of Death (Month, Day, Year): January 11 2001

3. Time of Death: 1820

4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-20-9595

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 25, 1927

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: HOWARD

10c. City, Town or Location: COLUMBIA

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10111 WINDSTREAM DRIVE

10f. Zip Code: 21044

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INVESTOR

16b. Kind of Business/Industry: FINANCIAL

17. Father's Name (First, Middle, Last): MOSES MILLER

18. Mother's Neme (First, Middle, Maiden Surname): ROSE DAVIDSON

19a. Informant's Name/Relationship (Type, Print): ANN MILLER / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10111 WINDSTREAM DRIVE - COLUMBIA, MD 21044

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HEBREW FRIENDSHIP CEMETERY

Date: 1/14/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Scott M. Cattle

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SYSTEMIC INFLAMMATORY RESPONSE SYNDROME — 3-5 DAYS

Due to (or as a consequence of):

b. CLOSTRIDIUM DIFFICILE COLITIS, SEVERE — 5-7 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael E Pelczar

29c. License number: D09990

29d. Date signed (Month, Day, Year): 01/12/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL E. PELCZAR M.D. ST. AGNES HOSPITAL 900 CATON AVE.

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

NAME Miller, DAVID B.

10

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00639

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): June E. Neal

2. Date of Death: Month 01 Day 09 Year 2001

3. Time of Death: 7:50p.m.

4a. Facility Name (If not institution, give street and number): Gilchrist Nursing Home

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 236-64-1406

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 06 03 41

9. Birthplace (State or Foreign Country): W.V.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7105 North Alter Street

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 4yrs+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: City Schools

17. Father's Name (First, Middle, Last): John Woods

18. Mother's Name (First, Middle, Maiden Surname): Darnella Anglin

19a. Informant's Name/Relationship (Type, Print): Jurea Neal-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7105 North Alter Street, Baltimore Md 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Date: 1/13/01

20c. Location - City or Town, State: Pikesville, Md

21. Signature of Funeral Service Licensee: Thomas L. Thompson

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinomatous meningitis	3 months
	Due to (or as a consequence of):	
	b. colon cancer	8 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Renee G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1/9/01 Neal, June 7:50 pm

DHMH 16 Rev 6/95

ORIGINAL

01-0179-510
GREGORY NEWMAN
ASP AMEND ITEMS: #23 PART I, 27 PER MEO G791 1-30-01 WR

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00640

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
GREGORY NEUMAN	JANUARY 11 2001	8:17 A

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3908 FOSTER AVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-48-8227	1[X] M 2[ ] F	47 Yrs.			Dec. 10, 1953	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3908 FOSTER AVENUE	21224	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		DISABLED	N/A

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
HARRY L. NEUMAN	HELEN BLUM

19a. Informant's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
HARRY L. NEUMAN, JR./ BROTHER	1737 DEEP RUN ROAD, WHITEFORD, MARYLAND 21160

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from Stete 4[ ] Donation 5[ ] Other (Specify)	ST. STANISLAUS CEMETERY	1/15/01	BALTIMORE, MARYLAND

21. Signature of Funeral Servica Licensee	22. Name and Address of Facility
[signature]	LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MARYLAND 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HYPERTROPHIC CARDIOMYOPATHY	
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as e consequenca of):		
	c.	
Due to (or es e consequenca of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cauee of death?** 1[ ] Yes 2[ ] No 3[ ] Probably 4[ ] Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[X] Yes 2[ ] No	1[X] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[X] Yes 2[ ] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Netural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
[signature]	O.C.M.E	JANUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. CARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signature
JAN 16 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 00641

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George M. Nessif
2. Date of Death Month / Day / Year: January 3 2001
3. Time of Death: 7:20 AM
4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 234-48-3691
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep 13, 1915
9. Birthplace *(State or Foreign Country)*: W. Va

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Woodbine
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15202 Carrs Mill Rd.
10f. Zip Code: 21797
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Distributor
16b. Kind of Business/Industry: Beverage

17. Father's Name *(First, Middle, Last)*: Mike Nessif
18. Mother's Name *(First, Middle, Maiden Surname)*: Hadley Forsley

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Richard Nessif
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15202 Carrs Mill Rd. Woodbine, Maryland 21797

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Spring Hill Cemetery
Date: 01/06/01
20c. Location - City or Town, State: , W. Va

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Beard Mortuary, Inc. 3001 3rd Avenue Huntington, WV 25702

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	SEPSIS	DAYS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Congestive heart failure	YEARS
Due to (or as a consequence of):		
c.	Renal failure	week.
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D22856
29d. Date signed *(Month, Day, Year)*: January 3, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Leroy I. Levenson MD 11055 Little Patuxent Pky, Columbia MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00642

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tina Novick
2. Date of Death (Month, Day, Year): January 8 2001
3. Time of Death: 0103
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-10-8878
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 24, 1907
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4 POMONA NORTH
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: U.S.F.&G.
17. Father's Name (First, Middle, Last): ISADORE NOVICK
18. Mother's Name (First, Middle, Maiden Surname): EVA LEVIN
19a. Informant's Name/Relationship (Type, Print): SAUL ROCKMAN / NEPHEW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 363 JERSEY STREET - SAN FRANCISCO, CA 94114
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WORKMENS CIRCLE CEMETERY
Date: 1/12/01
20c. Location - City or Town, State: DUNDALK, MD
21. Signature of Funeral Service Licensee: Scott M. Cattle
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Embolism
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dr. Lanny Harlan
29c. License number: H0051339
29d. Date signed (Month, Day, Year): January 8, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Lanny S. Harlan 5401 Old Court Road Randallstown MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature:

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00643

THEODORE PAJAK - JANUARY 12, 2001
Baltimore, Maryland 21215-0036 @ 6:00AM

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THEODORE PETER PAJAK
2. Date of Death (Month, Day, Year): JANUARY 12 2001
3. Time of Death: 6 A.M.
4a. Facility Name *(If not institution, give street and number)*: GILCHRIST CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 192-01-2013
6. Sex: ☒ M ☐ F
7. Age *(In yrs. last birthday)*: 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPTEMBER 1, 1916
9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: BEL AIR
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1809 BARRINGTON VILLAGE CT.
10f. Zip Code: 21014
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 YRS. College (1-4or 5+): 4 YRS
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ENGINEER
16b. Kind of Business/Industry: PRIVATE INDUSTRY

17. Father's Name *(First, Middle, Last)*: JOHN PAJAK
18. Mother's Name *(First, Middle, Maiden Surname)*: AGNES MISZAK

19a. Informant's Name/Relationship *(Type, Print)*: EUGENIA PAJAK
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1809 BARRINGTON VILLAGE COURT BEL AIR, MD 21014

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SACRED HEART OF MARY
Date: JAN. 15, 2001
20c. Location - City or Town, State: BALTIMORE MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS FUNERAL CHAPEL — BEL AIR, P.A. 2001 3 NEWPORT DRIVE FOREST HILL MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon cancer — 2 ½ years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other *(Specify)* Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature] H. Anthony Ruley - MD
29c. License number: D25205
29d. Date signed *(Month, Day, Year)*: JANUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A.R. Cap GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: [signature] Geneva G Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00644

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES WELDON PARKS
2. Date of Death Month Day Year: JAN 14 2001
3. Time of Death: 14:00
4a. Facility Name (If not institution, give street and number): 207 BROADCREEK
4b. City, Town, or Location of Death: WHITEFORD
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 217-64-2264
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 09, 1952
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Harford Co.
10c. City, Town or Location: Whiteford
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 207 Broad Creek
10f. Zip Code: 21160
10g. Citizen of What Country?: United States of America
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed
16b. Kind of Business/Industry: Social Security Disability
17. Father's Name (First, Middle, Last): Weldon Barry Parks
18. Mother's Name (First, Middle, Maiden Surname): Regina Adele van Reuth
19a. Informant's Name/Relationship (Type, Print): Mr. Weldon Barry Parks(Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Broad Creek Whiteford, Maryland 21160
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mays Chapel Cemetery
Date: 01/19/2001
20c. Location - City or Town, State: Timonium, Maryland
21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. END STAGE RENAL DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DME
29c. License number: OCME
29d. Date signed (Month, Day, Year): JAN 14, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GSPRABN MD 728 BELAIR RD BELAIR MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Deanna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23B PER PHY G791 1-16-01 WR.

Certificate of Death

Reg. No. 2001 00645

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
DORIS		PARKER	JANUARY	7	2001	2:54 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
225-46-7416	1☐ M XX F	70 Yrs.					10 18 30	N.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	XX Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2501 Violet Ave Apt 1209	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	na	Nursing	Bon Secour Hops.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Hezikah Newsome	Laila Jones

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carolyn Al-Mateen-Daughter	4201 Red Haven Road, Pikesville, Md 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Data	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	King Memorial Park	1/12/01	Randallstown, Md

21. Signature of Funeral Service Licensee: Clarence A. Thompson

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ~~Aspiration of Gastric Contents~~ ASPIRATION PNEUMONIA	36 Hours
Due to (or as a consequence of):	b. Diabetic Gastroparesis	2 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type 2 Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
David A. Rapko MD	20313	JANUARY 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID A. RAPKO, MD JOHNS HOPKINS BAYVIEW 4940 EASTERN AVE BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00646

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Archibald J. Parsons

2. Date of Death — Month: January Day: 14 Year: 2001

3. Time of Death: 2145 PM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 118-14-2074

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 9, 1925

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7425 Tupelo Drive

10f. Zip Code: 20855

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): — College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Journalist

16b. Kind of Business/Industry: Newspaper

17. Father's Name (First, Middle, Last): Archibald Jerome Parsons

18. Mother's Name (First, Middle, Maiden Surname): Dortha Tuck

19a. Informant's Name/Relationship (Type, Print): Sandra R. Parsons/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7425 Tupelo Drive Rockville, MD 20855

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. — Date: 1/16/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	respiratory insufficiency	minutes
Due to (or as a consequenca of): b.	Abdominal Aortic Aneurysm surgery	6 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or es e consequence of): c.	peripheral vascular disease	years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure - dialysis dependant

Cirrhosis of liver

Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) end menner stated.

29b. Signeture and title of certifier: Robert Fox

29c. License number: D24773

29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Fox 9715 Medical Center Drive, Rockville, Md. 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signeture: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00647

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marjorie C. Peters

2. Date of Death (Month, Day, Year): January 12, 2001

3. Time of Death: 2:45PM

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 074-26-2755

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 3, 1932

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4525 Valley Forge Drive

10f. Zip Code: 20853

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Leroy Rowe

18. Mother's Name (First, Middle, Meiden Surname): Anna Veronica Waters

19a. Informant's Name/Relationship (Type, Print): Melvin A. Peters/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4525 Valley Forge Drive, Rockville, Maryland 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Gate of Heaven Cemetery

Date: Jan. 17, 2001

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Ray Funk M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Acute Pulmonary Embolism — acute

Due to (or as a consequence of):

b. Lung Cancer — 3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Scleroderma

Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: Daniel Goldberg

29c. License number: D21334

29d. Date signed (Month, Day, Year): January 12, 2001

30. Name and address of person with ~~completed cause~~ of death (Item 23a) (Type, Print): DANIEL GOLDBERG, MD 6116 Executive Blvd Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [illegible] Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00648

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dean Phillips
2. Date of Death (Month, Day, Year): Jan. 11, 2001
3. Time of Death: 10:25PM
4e. Facility Name (If not institution, give street and number): 134 Monroe Street
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 545-14-9399
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 23, 1916
9. Birthplace (State or Foreign Country): Colorado

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 134 Monroe Street
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive
16b. Kind of Business/Industry: Aerospace

17. Father's Name (First, Middle, Last): Lester Phillips
18. Mother's Name (First, Middle, Maiden Surname): Elsie Cox

19a. Informant's Name/Relationship (Type, Print): Carole W. Phillips/Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 134 Monroe Street, Rockville, Maryland 20850

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: Jan. 14, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)
a. Congestive Heart Failure — 48 Hours

Due to (or as e consequence of):
b. Arteriosclerotic Cardiovascular Disease — 10 Years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Piece of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D21531
29d. Date signed (Month, Day, Year): Jan. 12, 2001
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): G. Peter Pushkas, MD 11510 Old Georgetown Rd., Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00649

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dora Wood Reynard
2. Date of Death: Month January Day 07, Year 2001
3. Time of Death: 9:40 P.M.
4a. Facility Name (If not institution, give street and number): Manor Care Towson
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 125-14-6509
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 28, 1915
9. Birthplace (State or Foreign Country): Sylvania, PA.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford Co.
10c. City, Town or Location: Belcamp
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 4345 Winner's Circle
10f. Zip Code: 21017
10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician
16b. Kind of Business/Industry: Hair Dresser

17. Father's Name (First, Middle, Last): Hiram G. Wood, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Evelyn G. Bixby

19a. Informant's Name/Relationship (Type, Print): Susan Reynard(Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4345 Winner's Circle Belcamp, Maryland 21017

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): East Canton Cemetery | Date: 01/11/2001
20c. Location - City or Town, State: East Canton, PA.

21. Signature of Funeral Service Licensee: ▶ Jeffrey L. Gair, Sr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bacterial Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D-43725
29d. Date signed (Month, Day, Year): 1/08/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tariq Mahmood, M.D. 201 Back River Neck Road Baltimore, Maryland 21221

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00650

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Henry Edward Reich

2. Date of Death Month / Day / Year: JANUARY 10 2001

3. Time of Death: 12:56 p.m.

4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-18-2082

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: SEPT 23, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 612 Ingleside Avenue

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Beer Salesman

16b. Kind of Business/Industry: Beer Distributor

17. Father's Name *(First, Middle, Last)*: August William Reich

18. Mother's Name *(First, Middle, Maiden Surname)*: Amanda Hipsley

19a. Informant's Name/Relationship *(Type, Print)*: Elinor Louise Reich/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 612 Ingleside Avenue Catonsville, MD 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery

Date: 1-13-01

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: George E. MacNabb

22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. midline cerebellar hemorrhage — 4 Days

Due to (or as a consequence of):

b. Congestive Heart Failure — 3 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: January 10 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jianxin Ma 600 N. Wolfe St Baltimore MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00651

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM ROGERS
2. Date of Death (Month, Day, Year): JANUARY 11, 2001
3. Time of Death: 9:50 AM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-54-8329
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 14, 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Pikesville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7 Sudbrook Lane
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Never Worked
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): William B. Rogers
18. Mother's Name (First, Middle, Maiden Surname): Katherine Burch

19a. Informant's Name/Relationship (Type, Print): John R. Rogers/Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1716 Linden Avenue Baltimore, MD 21217

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 1-12-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Disease
Seizure Dis.
Down's Syndrome

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D44505
29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.J. IMPERIAL, Jr. MD — Nashe.

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00652

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Salvatore Ravita

2. Date of Death: Month 1 Day 11 Year 01

3. Time of Death: 10 Pm

4a. Facility Name (If not institution, give street and number): 1114 Gregory Avenue

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-16-2670

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): June 30, 1917

9. Birthplace (State or Foraign Country): Maryland

Usual Rasidence of Decedent

10a. Steta: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1114 Gregory Avenue

10f. Zip Coda: 21207

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No. If Yes, Giva Yeer or Detes: WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxicen, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementery/Secondery (0-12): Collega (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): Pharmacist

16b. Kind of Business/Industry: Inman Drugs

17. Fathar's Nama (First, Middla, Last): Domenic Ravita

18. Mothar's Nama (First, Middle, Maiden Surnama): Antoinette Ponticello

19a. Informant's Name/Ralationship (Type, Print): John Ravita- son

19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code): 1114 Gregory Avenue, Catonsville, Maryland 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): New Cathedral Cemetery

Data: 01/16/2001

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signatura of Funaral Sarvice Licensee: Bernard DeLuca

22. Nama and Address of Facility: Witzke Funeral Home of Catonsville, 1630 Edmondson Avenue, Catonsville, Maryland 21228

Physician /Medical Examiner

23a. Part1. Enter the disaesa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiretory arrast, shock, or haart failura. List only ona causa on aach line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Cancer Lung — Dua to (or as a consequance of): — 1 year

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated evants resulting in death) Last

b. Dua to (or as a consequance of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yas 2 [X] No

26. Plece of Death (Check only ona): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA. Othar: 4 [ ] Nursing Homa 5 [X] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Dete of Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, date and place, and dua to tha ceuse(s) and mannar steted.

29b. Signature and title of certifier: Raafat Y. Girgis

29c. Licensa number: D31726

29d. Data signed (Month, Day, Year): 1-12-01

30. Neme and address of person who completed causa of daath (Item 23a) (Type, Print): RAAFAT Y. GIRGIS 724 Maiden Choice LA- Catonsville

State Registrar

31. Data filed (Month, Dey, Year): JAN 16 2001

32. Registrar's Signatura: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00653

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Samuel Charles Rainey

2. Date of Death Month Day Year: January 14, 2001

3. Time of Death: 4:56 PM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-26-9193

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 12, 1927

9. Birthplace *(State or Foreign Country)*: Philippines

Usual Residence of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9407 Corsica Drive

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): Collega (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT use retired)*: Nuclear Physicist

16b. Kind of Business/Industry: U.S. Navy

17. Father's Nama *(First, Middle, Last)*: Cecil Dubois Rainey

18. Mothar's Nama *(First, Middla, Maiden Sumama)*: Mariamna Blanche Rucker

19a. Informant's Name/Ratationship *(Type, Print)*: Mary R.P. Rainey/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 9407 Corsica Drive, Bethesda, Maryland 20814

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematery, cramatory or other place)*: Montgomery Crematorium, Inc.

Data: January 16, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Robert L. [illegible] M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on aach line.

Approximate Intarval Batween Onsat and Death

Immediata Causa (Final disease or condition resulting in death)

a. Cancer of Colon — 2 months

Dua to (or as a consequenca of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or injury that initiated events rasulting in death) Last

b.

Dua to (or as a consequanca of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

Renal Failure

Anemia

Anoxic Brain Damage

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledga, daath occurrad at tha tima, date and placa, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Ralph M. Coan M.D.

29c. License number: D01191

29d. Date signed *(Month, Day, Year)*: January 14, 2001

30. Nama and addrass of parson who complatad causa of death (Item 23a) (Type, Print): Ralph M. Coan, M.D. 9618 Culver Street, Kensington, Maryland 20895

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: [illegible] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00654

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gordon Redmond
2. Date of Death (Month, Day, Year): January 13 2001
3. Time of Death: 5am
4a. Facility Name *(If not institution, give street and number)*: Forest Haven Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217 07 6787
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 8, 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: None
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 112 Upmanor Road
10f. Zip Code: 21229
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:
13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Painter
16b. Kind of Businass/Industry: Westinghouse

17. Father's Name *(First, Middle, Last)*: Gordon Joseph Redmond
18. Mother's Name *(First, Middle, Meiden Surnema)*: Mary Genevieve Brewer

19a. Interment's Neme/Relationship *(Type, Print)*: Brian Redmond/Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 128 Malbrook Road Catonsville, MD 21229

20a. Method ot Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Plece of Disposition *(Nema of cemetery, cremetory or other placa)*: Loudon Park Cemetery
Date: 1-16-2001
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Donna Collins 10029446 Witzke
22. Neme end Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complicetions that caused the death. Do not enter the mode ot dying, such es cardiac or respiretory arrest, shock, or heart teilure. List only one ceuse on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Chronic Obstructive Pulmonary Disease

Due to (or as e consequence ot):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
b.
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other aignificant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. **Did tobacco use contributa to the cauae of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Plece of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Tima of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, tarm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best ot my knowledge, death occurred at the time, dete and plece, and due to the ceuse(s) and menner es steted. 2 [ ] **Medical Examiner**: On tha basis ot axemination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: Tasneem Lakhani
29c. License number: D28595
29d. Date signed *(Month, Day, Year)*: Jan 15, 2001

30. Name end address ot person who completed cause ot death (Item 23a) (Type, Print): Tasneem Lakhani 7220 Park Heights Ave Baltimore, MD 21208

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#19a perINFG791 1/19/2001 EW

Certificate of Death

Reg. No. 2001 00655

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose Rizzo

2. Date of Death: Month January Day 14 Year 2001

3. Time of Death: 5:39pm

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital 5601 Loch Raven Boulevard

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-07-0457

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 9, 1912

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6697 Loch Hill Rd.

10f. Zip Code: 21239

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Joseph DiGiorgio

18. Mother's Name (First, Middle, Maiden Surname): Rosalie Domina

19a. Informant's Name/Relationship (Type, Print): Mary ~~Marry~~ G. Rizzo-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6697 Loch Hill Rd., Baltimore, MD 21239

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corporation

Date: 1/16/01

20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: William G. Dau

22. Name and Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214

Physician Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immedlete Cause (Final diseese or condition resulting in death)

a. arrhythmia — 1-5 sec

Due to (or as a consequence of):

b. ischemia — 10 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

Due to (or as a consequence of):

c. hypovolemia — 2 hours

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

chronic renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner**: On the basis ot examination and/or Investigetion, in my opinion, death occurred at the time, dele and place, and due to the cause(s) and menner stated.

29b. Signeture end litle of certifier: Lisa Rosenberg MD

29c. License number: P13637

29d. Dele signed (Month, Dey, Year): January 14, 2001

30. Name and address of person who completed cause ot deeth (Item 23a) (Type, Print): Lisa Rosenberg, MD 5601 Loch Raven Boulevard Baltimore 21239

State Registrar

31. Dete tiled (Month, Day, Year): JAN 16 2001

32. Registrar's Signatura

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00656

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Roberta May Rohe

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 1:07 AM

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-4007

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 25 1925

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 34 Royal Ann Court

10f. Zip Code: 21237

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Line Person

16b. Kind of Business/Industry: Horn&Horn Cafeteria

17. Father's Name *(First, Middle, Last)*: Robert Fryer

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah O'Neill

19a. Informant's Name/Relationship *(Type, Print)*: Winfred J. Rohe /husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 34 Royal Ann Court Baltimore MD. 21237

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro CRematory INc.

Date: 1/13/01

20c. Location - City or Town, State: Balitmore Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce AVe. Balitmore Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease — 15 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Julie Ann P Casani MD

29c. License number: D28219

29d. Date signed *(Month, Day, Year)*: January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julie Ann Casani MD 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: ▶ Donna G Sparks

Rohe, Roberta
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00657

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Rogers, Jr.

2. Date of Death (Month, Day, Year): January 10, 2001

3. Time of Death: 11:05am

4a. Facility Name *(If not institution, give street and number)*: Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-24-0631

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 15, 1929

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1315 W. 40th Street

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employeed

16b. Kind of Business/Industry: Contractor

17. Father's Name *(First, Middle, Last)*: William Rogers, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Rea Denner

19a. Informant's Name/Relationship *(Type, Print)*: Doug Rogers (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1540 Gleneagle Road Baltimore, MD 21239

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Manchester Lutheran C

Date: 1/13/01

20c. Location - City or Town, State: Manchester, MD

21. Signature of Funeral Service Licensee: Tracy H. Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Rd. Baltimore, Md 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS WITH SEPTIC SHOCK

Due to (or as a consequence of):

b. Enterococcal Bacteremia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Cirrhosis

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hepatic Hydrothorax
Malnutrition

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mitchell S. Schwartz

29c. License number: D-44728

29d. Date signed *(Month, Day, Year)*: 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mitchell L. Schwartz 6569 N. Charles St Suite 601 Baltimore 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Rogers, W. 1/11/01

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00658

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy J. Routh
2. Date of Death Month Day Year: January 10, 2001
3. Time of Death: 10:20 AM
4a. Facility Name *(If not institution, give street and number)*: 2126 Sweetbriar Lane
4b. City, Town, or Location of Death: Lutherville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 223-30-8790
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 17, 1926
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2126 Sweetbriar Lane
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Johnston
18. Mother's Name *(First, Middle, Maiden Surname)*: Mabel Goodwin

19a. Informant's Name/Relationship *(Type, Print)*: Alfred M. Routh
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2126 Sweetbriar Lane, Lutherville, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem. Grdns. | Date: 1/13/01
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung cancer — 8 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anthony Riley MD
29c. License number: D25205
29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 3 per ME,G-792,02/08/01,dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00659

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): **James Colbert Rothe**

2. Date of Death Month Day Year: Jan 10, 2001

3. Time of Death: 1655

4a. Facility Name (If not institution, give street and number): 7810 Clark Road #A21

4b. City, Town, or Location of Death: Jessup

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-74-9814

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 36 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 14, 1964

9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Jessup

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7810 Clark Road

10f. Zip Code: 21076

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed

16b. Kind of Business/Industry: Unemployed

17. Father's Name (First, Middle, Last): Jack Frank Rothe

18. Mother's Name (First, Middle, Maiden Surname): Monica Colbert

19a. Informant's Name/Relationship (Type, Print): Mrs. Monica R. Fabbri

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6906 Raven Lane Columbia, Maryland 21044

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Cemetery

Date: 01/15/01

20c. Location - City or Town, State: Ellicott City, MD

21. Signature of Funeral Service Licensee: [signature] 100535

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Diabetic Ketoacidosis — Days.

Due to (or as a consequence of):

b. Diabetes Mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Narcotics Addiction

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Deputy ME

29c. License number: D 06054

29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0148-510

DEMITRIUS SMITH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00660

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Demetreus Smith

2. Date of Death: Month JANUARY Day 9 Year 2001

3. Time of Death: 1:16P.M.

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: unk

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs, last birthday): 23 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 23, 1977

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 2138 W. Patapsco Ave.

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Forklift Operator

16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): Melvin Smith

18. Mother's Name (First, Middle, Maiden Surname): Bertha Armstrong

19a. Informant's Name/Relationship (Type, Print): Bertha Coles - mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2138 W. Patapsco Ave. Balto., md. 21230

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery

Date: 1/15/01

20c. Location - City or Town, State: Lansdowne, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Gary L. March Funeral Home P.A. 2470 Fredhilton Pass Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1-9-01

28b. Time of Injury: 1235 p M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): inside a laundra mat

28f. Location (Street and Number or Rural Route Number, City or Town, State): Benedict laundry 2642 E. Monument St, Baltimore, MD

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis Chutkow

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutkow 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00661

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: OLIVIA SMITH
2. Date of Death Month Day Year: JAN 07 2001
3. Time of Death: 8 00 PM
4a. Facility Name *(If not institution, give street and number)*: MERCY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-44-7566
6. Sex: 1☐ M 2☐ F XX
7. Age *(In yrs. last birthday)*: 54 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 05-10-46
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 1037 N. Aisquith Street
10f. Zip Code: 21202
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Unemployed
16b. Kind of Business/Industry: Unemployed

17. Father's Name *(First, Middle, Last)*: Thomas Jones
18. Mother's Name *(First, Middle, Maiden Surname)*: Martha Blake

19a. Informant's Name/Relationship *(Type, Print)*: Shawan Fullard
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3204 Yosemite Avenue Baltimore, MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sacred Heart of Jesus
Date: 01-17-01
20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: ▶ Gladys Warner
22. Name and Address of Facility: Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 5 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ~~4☒~~ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joseph Costa, MD
29c. License number: D42634
29d. Date signed *(Month, Day, Year)*: JAN 07, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH COSTA 301 ST PAUL PLACE BALTIMORE, MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD
01-0106-510
01-007
Clarence Sneed

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00662

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARENCE EDWARD SNEED JR.

2. Date of Death — Month: JANUARY Day: 6, Year: 2001

3. Time of Death: 7:30P.M.

4a. Facility Name *(If not institution, give street and number)*: 1200 BLK. RIGGS AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 215-88-5653

6. Sex: 1☑M 2☐F

7. Age *(In yrs. last birthday)*: 35 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: OCT. 3, 1965

9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10a. State: M.D.

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑Yes 2☐No

10e. Street and Number: 654 QUEENSGATE ROAD

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐Yes 2☑No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☑No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LANDSCAPING

16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: CLARENCE E SNEED SR

18. Mother's Name *(First, Middle, Maiden Surname)*: ALBERTA BROWNSON

19a. Informant's Name/Relationship *(Type, Print)*: MARTHA SNEED _ SISTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 654 QUEENSGATE RD, BALTO., M.D. 21229

20a. Method of Disposition: 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METRO CREMATORY

Date: 1/15

20c. Location - City or Town, State: CATONSVILLE, M.D.

21. Signature of Funeral Service Licensee: Willie E Howell Jr.

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGTS. AVE., BALTO., M.D. 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gunshot wound of the head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 1-06-2001

28b. Time of Injury: 1929 M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: Subject was shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Alley

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 1200 block Riggs Avenue Baltimore City, Maryland

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JANUARY 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: James G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00663

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry A. Segal

2. Date of Death: Month January, Day 12, Year 2001

3. Time of Death: 9:00 AM

4a. Facility Name (If not institution, give street and number): 3713 Chevy Chase Lake Drive #2

4b. City, Town, or Location of Death: Chevy Chase

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 200-10-2822

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Nov. 16, 1921

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3713 Chevy Chase Lake Drive #2

10f. Zip Code: 20815

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943–1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Psychiatrist

16b. Kind of Business/Industry: Medicine

17. Father's Name (First, Middle, Last): Louis Segal

18. Mother's Name (First, Middle, Maiden Surname): Helen Sonnheim

19a. Informant's Name/Relationship (Type, Print): Robert Mark Segal/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7832 Rogues Road, Catlett, Virginia 20119

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: Jan. 14, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — minutes

Due to (or as a consequence of):

b. Emphysema — 10 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ankylosis Spondylitis, Chronic Lower Extremity Edema

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: MD13891

29d. Date signed (Month, Day, Year): Jan. 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brian C. Turrisi, MD 2440 M Street, NW, Suite 810, Washington, DC 20037

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: ▶ [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00664

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert O. Sterling	January 12, 2001	9:50AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-34-0505	X 1 M 2 F	63 Yrs.			Apr 18, 1937	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1 Yes X 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6047 Gwynn Oak Avenue	21207	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married X 2 Married 3 Widowed 4 Divorced	1 Yes X 2 No If Yes, Give Year or Deteas:	1 Yes X 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		General Motor	Assembly Line Worker

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry O. Sterling	Naomi Wells

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Viola M. Sterling-Wife	6047 Gwynn Oak Avenue, Baltimore, MD 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Metro Crematory	Jan 17 2001	Catonsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Calvin L. Williams	Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	9 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 X **Yes** 2 **No** 3 **Probably** 4 **Unknown**

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	▶ [illegible] G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00665

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothea R. Stewart

2. Date of Death: Month January Day 09, Year 2001

3. Time of Death: 7:20 A.M.

4a. Facility Name (If not institution, give street and number): Dulaney Towson Nursing Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 421-10-0953

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 19, 1913

9. Birthplace (State or Foreign Country): Ft. Wayne, Indiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 12 Edgemoor Road

10f. Zip Code: 21093

10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 02

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Office Manager

17. Father's Name (First, Middle, Last): Frederick Rasch

18. Mother's Name (First, Middle, Maiden Surname): Martha Unknown

19a. Informant's Name/Relationship (Type, Print): Mr. James C. Stewart(Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Edgemoor Road Timonium, Maryland 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corporation

Date: 01/13/2001

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: ▶ Jeffrey L. Gair, Sr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sneesh Tripurani

29c. License number: D 30661

29d. Date signed (Month, Day, Year): January 9th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sneesh TRIPURANENI 5601 Loch Raven Blvd. Baltimore, Md - 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: ▶ G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00666

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis Robert Schiefer

2. Date of Death: Month JANUARY Day 11 Year 2001

3. Time of Death: 4:22 A.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-28-7840

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 11, 1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4003 St. Augustine Lane

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lubrication Maintenance

16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): Charles J. Schiefer

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth B. Kevet

19a. Informant's Name/Relationship (Type, Print): Mrs. Theresa G. Schiefer (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4003 St. Augustine Lane Dundalk, Maryland 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Holly Hill Memorial Gardens. Date: 1/15/2001

20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral Service Licensee: Denise C. Carroll

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ATHEROSCLEROSIS OF CORONARY ARTERIES, SEVERE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. CARDIOMEGALY

Due to (or as a consequence of):

c. LEFT VENTRICULAR HYPERTROPHY

Due to (or as a consequence of):

d. PROBABLE ARRHYTHMIA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier:

29c. License number: D47658

29d. Date signed (Month, Day, Year): JANUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KIUMARCE KHASHI, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

SCHIEFER, FRANCIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #20C PER F.H. G791 1-16-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00667

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARKADIY SOLOVEY
2. Date of Death (Month, Day, Year): January 12 2001
3. Time of Death: 1258
4a. Facility Name (If not Institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-39-3355
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 25 1929
9. Birthplace (State or Foreign Country): BELARUSA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1500 BEDFORD AVE.APT. 507
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: MACHINERY

17. Father's Name (First, Middle, Last): ZALMAN SOLOVEY
18. Mother's Name (First, Middle, Maiden Surname): FAINA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): SEMEN SOLOVEY/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 122 WINDBLOWN COURT BALTIMORE, MD.21209

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): BETH EL MEMORIAL PARK
Date: 1/14/01
20c. Location - City or Town, State: RANDALSTOWN, MD ~~WOODLAWN, MD.~~

21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
b. Cardiovascular Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patrick McGinley M.D. Patrick McGinley
29c. License number: D0054482
29d. Date signed (Month, Day, Year): January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrick McGinley M.D. 2401 West Belvedere Ave Balt, MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Barbara A Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Solovey, Arkadiy
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00668

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVA STEINBERG
2. Date of Death (Month, Day, Year): JANUARY 12, 01
3. Time of Death: 10:10 AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-28-0513
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 27, 1903
9. Birthplace (State or Foreign Country): RUSSIA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3601 FORDS LANE #813
10f. Zip Code: 21215
10g. Citizen of What Country: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALES
16b. Kind of Business/Industry: RETAIL

17. Father's Name (First, Middle, Last): HYMAN SHAPIRO
18. Mother's Name (First, Middle, Maiden Surname): ROSE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): SHIRLEY GUDIS / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9119 GROFFS MILL ROAD - OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MIKRO KODESH BETH ISRAEL
Date: 1/14/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K.S. RAO. M.D
29c. License number: 043462
29d. Date signed (Month, Day, Year): JANUARY 12, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.S. RAO. M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00669

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MISHEL SEIDEL

2. Date of Death Month Day Year: January 11, 2001

3. Time of Death: 10:30pm

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-22-3443

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APR. 19, 1916

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2721 GLEN AVENUE

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5+ College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MERCHANT

16b. Kind of Business/Industry: MUSIC

17. Father's Name *(First, Middle, Last)*: HERMAN SEIDEL

18. Mother's Name *(First, Middle, Maiden Surname)*: ROSE FINKELSTEIN

19a. Informant's Name/Relationship *(Type, Print)*: BETTY SEIDEL / WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2721 GLEN AVENUE - BALTIMORE, MD 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARLINGTON CHIZUK AMUNO

Date: 1/12/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Jay Alan Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Reuven Ogrogen MD

29c. License number: P14279

29d. Date signed *(Month, Day, Year)*: January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2400 West Belvedere Rd, Baltimore Maryland 21209

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Geneva B Jones

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Seidel, Mishel

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00670

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RALPH SUGAR.

2. Date of Death: Month: Jan; Day: 11th.; Year: 2001

3. Time of Death: 2.40am.

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore.

4b. City, Town, or Location of Death: Baltimore.

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-01-1456

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 3, 1907

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7 SLADE AVENUE #118

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - American Indien, Bieck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: PROPRIETOR

16b. Kind of Business/Industry: RETAIL

17. Father's Name *(First, Middle, Last)*: NATHAN SUGAR

18. Mother's Name *(First, Middle, Maiden Sumeme)*: RACHEL (UNKNOWN)

19a. Informant's Name/Relationship *(Type, Print)*: RENA B. SUGAR / WIFE

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7 SLADE AVENUE #118 - BALTIMORE, MD 21208

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: BALTIMORE HEBREW CEMETERY

Date: 1/12/01

20c. Location - City or Town, State: REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: Michael Krugman

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death) a.	Intracranial Haemorrhage	1 HR.
Due to (or as a consequence of): b.	Hypertension.	More than 10 years
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Atrial Fibrillation	1 year.
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Merner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Tariq Khan MD

29c. License number: D21730.

29d. Date signed *(Month, Dey, Year)*: Jan 11 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ KHAN 2401 West Belvedere Ave. Baltimore, Md. 21215

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 16 2001

32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Sugar Ralph

01-0216-510
cm
Monroe L. Thompson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00671

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Monroe L. Thompson
2. Date of Death: Month January Day 13, Year 2001
3. Time of Death: 2:25 P.M.
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-18-7794
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 30, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1621 Glen Keith Boulevard
10f. Zip Code: 21286
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: State of Maryland

17. Father's Name (First, Middle, Last): Joseph Thompson
18. Mother's Name (First, Middle, Maiden Surname): Mary Moore

19a. Informent's Neme/Reletionship (Type, Print): Athena Thompson/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1621 Glen Keith Boulevard, Towson, Maryland 21286

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): Metro Crematory, Inc.
Date: 01-15-01
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licansee: ▶ M. Neal Coleman
22. Name end Address of Facility: The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Sepsis

Due to (or as a consequenca of):
Respiratory Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last
b. Due to (or as a consequenca of): Head and Neck Injuries
c. Due to (or as a consequence of):
d.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 12-14-2000
28b. Time of Injury: unknown P M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject fell down stairs.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street end Number or Rural Route Number, City or Town, State): 1621 Glen Keith Boulevard, Towson, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ R M Madayag
29c. License number: D0050934
29d. Date signed (Month, Day, Year): January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. M. Madayag, M.D. 22 South Greene Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ Donna G Watts

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00672

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY TAYLOR

2. Date of Death: Month JANUARY Day 13 Year 2001

3. Time of Death: 11:00 AM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE.

4c. County of Death: BALTIMORE.

Funeral Director

5. Social Security Number: 213-16-9580

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 19, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6225 York Road #409

10f. Zip Code: 21212

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Private family

17. Father's Name (First, Middle, Last): Louis Frazier, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Angeline Ringgold

19a. Interment's Name/Relationship (Type, Print): Mabel Frazier / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225

2717 Spellman Road #A2 Baltimore, Md

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Pleasant Rest Cemetery

Date: 1-18-2001

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Larry Harris

22. Name and Address of Facility: CARTMAN-HOWARD FUNERAL HOME 5246 REISTERSTOWN ROAD Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CVA

Due to (or as a consequence of):
b. Ischemic cardiomyopathy.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD.

29c. License number: P-13456

29d. Date signed (Month, Day, Year): JANUARY 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUISA MUNOZ, 6920 Donahue Rd Apt 1609, Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00673

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aldo Giacomo Tassi
2. Date of Death: Month: January Day: 10 Year: 2001
3. Time of Death: 0020
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 076-26-3317
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 10, 1933
9. Birthplace (State or Foreign Country): New York, New York

Usual Residence of Decedant

10a. State: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 204 East Joppa Road Apt.1217
10f. Zip Code: 21286
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Peace Time
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor of Philosophy
16b. Kind of Business/Industry: Education/ Loyola College

17. Father's Name (First, Middle, Last): Mario Benedetto Tassi
18. Mother's Name (First, Middle, Maiden Surname): Mary Gazzotti

19a. Informant's Name/Relationship (Type, Print): (Wife) Nina Marguerite(nee Carey)Tassi, Ph.D.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 East Joppa Road Apt.1217 Towson, Maryland 21286

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens
Date: 01/13/2001
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr. — Jeffrey L. Gair, Sr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. metastatic esophageal cancer — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kerry Dunbar MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kerry Dunbar MD 600 North Wolf Street Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Theresa G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00674

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN A. THELEN

2. Date of Death — Month: JAN Day: 12 Year: 2001

3. Time of Death: 2200

4a. Facility Name (If not institution, give street and number): MARINER HEALTH & REHAB @ NORTH ARUNDEL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 100.16.3980

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAR 3 1924

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 462 GLEN MAR RD.

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): UNK — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SERVICES/SETUP

16b. Kind of Business/Industry: USO

17. Father's Name (First, Middle, Last): FELIX SWARKO

18. Mother's Name (First, Middle, Maiden Surname): MARY SWARKO

19a. Informant's Name/Relationship (Type, Print): KEN THELEN SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2652 BIRD VIEW RD.WESTMINISTER,MD 21157

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY,INC

Date: 1/16/01

20c. Location - City or Town, State: BALTIMORE,MD

21. Signature of Funeral Service Licensee: K. GREGORY FINK

22. Name and Address of Facility: FINK FUNERAL HOME,P.A. 426 CRAIN HWY., S. GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma of Cervix	1 Year
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension	10 years.
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 40519

29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mirza M. Nusairat, 7845 Oakwood, Pasadena Hills, Glen Burnie, 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00675

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leona Urban

2. Date of Death (Month, Day, Year): JANUARY 7, 2001

3. Time of Death: 3:02AM

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 213-09-6185

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 17, 1911

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7355 Furnace Branch Road

10f. Zip Code: 21060

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+)

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cutter

16b. Kind of Business/Industry: Garment Factory

17. Father's Name *(First, Middle, Last)*: Samuel Thomas Gary, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Regina Reely

19a. Informant's Neme/Reletionship *(Type, Print)*: Allen C. Gary/nephew

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8203 New Cut Road Severn, MD 21144

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.

Date: 1/12/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)

a. Cardiac arrhythmia — few Mins

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rani S. Karipineni M.D

29c. License number: D26307.

29d. Date signed *(Month, Day, Year)*: 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RANI S. KARIPINENI 4000 ANNAPOLIS RD BALTIMORE, MD 21227.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

URBAN LEONA M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00676

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathryn Edna Vandiver
2. Date of Death (Month, Day, Year): January 13, 2001
3. Time of Death: 8:50 PM
4a. Facility Name (If not institution, give street and number): Crofton Convalescent Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 488-28-3193
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): JUNE 8, 1925
9. Birthplaca (State or Foraign Country): Missouri

Usual Residance of Dacedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1422 Knightsbridge Turn
10f. Zip Code: 21114
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaer or Datas:
13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White
15. Decedant's Education (Specify only highest grada compiated): Elamentary/Secondary (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Homemaker
16b. Kind of Businass/Industry: Own Home
17. Fether's Nama (First, Middle, Last): Henry Bremer
18. Mother's Nama (First, Middla, Maiden Sumama): Kathryn Lynch
19a. Informant's Name/Ralationship (Type, Print): Paul H. Vandiver/Husband
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1422 Knightsbridge Turn Crofton, MD 21114
20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, crematory or othar placa): Metro Crematory Inc.
Date: 1-15-01
20c. Location - City or Town, Stata: Baltimore, MD
21. Signature of Funaral Service Licansee: Edward A. Gregorchik
22. Nama and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onsat and Death

Immediata Cause (Finel disaasa or condition rasulting in daath): a. Metastatic Carcinoma OF Lung — Months

Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseese or injury thet initiated evants rasulting in death) Last:
b. Dua to (or as a consaquanca of):
c. Due to (or as a consaquanca of):
d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying causa givan in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to compiation of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☑ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Rasidanca 8☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only ona): 1☑ Certifying Physician: To the best of my knowledga, daath occurred at tha time, data and plece, and due to tha causa(s) and manner as stated. 2☐ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar steted.

29b. Signeture and title of certifier: Rakesh Arora
29c. Licansa number: D 20108
29d. Data signed (Month, Day, Year): January 15, 2001

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): RAKESH ARORA 14300 GALLANT FOX LN # 222 Bowie, MD 20720

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrer's Signature: D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00677

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NATASHA WILLIAMS

2. Date of Death: Month 01 Day 10 Year 01

3. Time of Death: 7:30 AM

4a. Facility Name (If not institution, give street and number): CATONSVILLE COMMONS

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-42-0857

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): MAY 30, 1944

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residance of Decedant

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 726 N. CARROLLTON AVE

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highast grada completed): Elamentary/Secondary (0-12): 11th; Collega (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): BAR TENDER

16b. Kind of Business/Industry: BAR

17. Fathar's Nama (First, Middla, Last): JAMES MATTHEW BROWN SR.

18. Mother's Nama (First, Middle, Maiden Surnama): MARY ELIZABETH SAMPSON

19a. Informant's Name/Ralationship (Type, Print): MARSHA TAYLOR-SISTER

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 3018 WAYNE AVE. BALTIMORE, MARYLAND 21207

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or other place): METRO CREMATORY

Data: 1/16/00

20c. Location - City or Town, Stata: CATONSVILLE, MD.

21. Signatura of Funaral Service Licensaa: LEWIS T. GWYNN — Lewis T. Gwynn

22. Nama and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haart failura. List only ona causa on each line.

Approximata Intarval Between Onset and Death

Immedieta Causa (Final disaasa or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DIS — YRS

Due to (or as a consequence of):

b. HYPERTENSION — YRS

Sequantially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Diseasa or Injury that initiated events rasulting in daath) Last

Due to (or as a consequence of):

c. TOBACCO USE — YRS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not rasulting in tha underlying causa given in Part I.

CIRRHOSIS, MITRAL, TRICUSPID VALVE REPLACEMENTS,

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On tha basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: Kenneth M [illegible] MD

29c. License number: D20333

29d. Data signed (Month, Day, Year): 1/12/2001

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print): 1838 GREENTREE RD PIKESVILLE MD/ZONIES

State Registrar

31. Data filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signatura: Diane G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00678

Pt. known as Johnnie M. Ward

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHNNIE M. WARD

2. Date of Death: Month January Day 11, Year 2001

3. Time of Death: 1142 pm

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 240-24-2577

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 5, 1920

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3400 GWYNNSFALLS PKWY.

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1941 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STEEL WORKER

16b. Kind of Business/Industry: STEEL MILL

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): ELLA MAE WARD

19a. Informant's Name/Relationship (Type, Print): CRAIG BRUNSON-STEP SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3312 RAYONNE AVE. BALTO. MD. 21214

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VET. Date: 1/22/01

20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Lewis T. Gwynn LEWIS T. GWYNN

22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Edema

Due to (or as a consequence of):

b. Metastatic Lung Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Lung Cancer

(2) Pneumectomy

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D0056388

29d. Date signed (Month, Day, Year): 1/12/2001

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): Sinai Hosp. 2401 W. Belvedere Balt, MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00679

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph McKinley Ward, Jr.

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 8:30 AM

4a. Facility Name *(If not institution, give street and number)*: 2299 Lowell Ridge Rd Apt A

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-18-3144

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 24, 1924

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2299 Lowell Ridge RD Apt A

10f. Zip Code: 21234

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Groom

16b. Kind of Business/Industry: Thoroughbread Horsefarm

17. Father's Name *(First, Middle, Last)*: Joseph McKinley Ward, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Blanche Hunt

19a. Informant's Name/Relationship *(Type, Print)*: Elenere M. Ward / wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2299 Lowell Ridge Rd Apt A Parkville, MD 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory, Inc.

Date: 1/16/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — 25yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deputy

29c. License number: D18667

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Phil P Militello, MD Shock Trauma 22 S. Greene ST. Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 10e,19b per fh G791 1/18/01 yf

Certificate of Death

Reg. No 2001 00680

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edgar Arthur Weimer
2. Date of Death Month Day Year: JANUARY 15, 2001
3. Time of Death: 10:42 AM
4e. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 209-24-6229
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 5 1928
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 23 Orthoridge Road ~~23 Othoridge Rd.~~
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed
16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Charles Weimer
18. Mother's Name *(First, Middle, Maiden Surname)*: Della Morgan

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Ann P. Weimer/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: ~~23 Othoridge Rd~~ 23 Orthoridge Road, Lutherville, Md. 21093

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens Of Faith Cemetery
Date: 1-18-01
20c. Location - City or Town, State: Overlea, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC COLON CANCER — 3 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D 36814
29d. Date Signed *(Month, Day, Year)*: 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD HUSLIG, M.D., 7601 ~~BOLER~~ DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: [signature]

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ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2001 JAN 16 AM 4:00

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00681

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ternae Williams
2. Date of Death Month Dey Year: Jan. 12, 2001
3. Time of Death: 9:50am
4a. Facility Name *(If not institution, give street end number)*: 2211 Aiken Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 217-57-0028
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Year Months: 9; Deys; If Under 24 Hrs. Hours; Min.
8. Date of Birth *(Month, Dey, Year)*: 04-06-2000
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2211 Aiken Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Meritel Status: 1☒Never Married 2☐Merried 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Reca - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): Infant; College (1-4or 5+): Infant
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Infant
16b. Kind of Business/Industry: Infant

17. Father's Neme *(First, Middle, Last)*: Robert Smith
18. Mother's Neme *(First, Middle, Meiden Sumeme)*: Teresa Williams

19a. Inlorment's Name/Reletionship *(Type, Print)*: Teresa Williams
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2211 Aiken Street Baltimore, Maryland 21218

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, cremetory or other plece)*: Druidridge Cemetery
Dete: 01-17-01
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Darrell L. Hunter
22. Neme end Address of Feciliity: Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in deeth)
e. Glioblastoma Multiforme

Due to (or es a consequenca ol):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last
b.

Due to (or es e consequenca ol):
c.

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Seizures

Hydrocephalus

Cardiorespiratory Arrest

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*
Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 8☐Other *(Specify)*

27. Manner of Death: 1☐Neturel 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) end manner as stated. 2☐**Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Virginia Keane MD
29c. License number: D32410
29d. Dete signed *(Month, Day, Year)*: January 12, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Dr. Virginia Keane, MD 105 Penn Street Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 16 2001
32. Registrer's Signeture: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Ternae Williams

Baby

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00682

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine M. Williamson
2. Date of Death — Month: January Day: 13, Year: 2001
3. Time of Death: 9:40 PM
4a. Facility Name *(If not institution, give street and number)*: 1009 Crawford Drive
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 236-40-4428
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 23, 1927
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1009 Crawford Drive
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Burl Nettles
18. Mother's Name *(First, Middle, Maiden Surname)*: Ada Jack

19a. Informant's Name/Relationship *(Type, Print)*: Carl W. Williamson/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1009 Crawford Drive, Rockville, Maryland 20851

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park
Date: Jan. 17, 2001
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Cardiopulmonary Failure	Acute
Due to (or as a consequence of):		
b.	Lung Cancer	Chronic
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
26e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Wallmark M.D.
29c. License number: 53177
29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John M. Wallmark, M.D. 10605 Concord Street, Suite 300, Kensington, Maryland 20895

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #31 PER D.V. R. G791 1-14-01 WR. *Certificate of Death* Reg. No. 2001 00683

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): **John William Werking, Jr.**

2. Date of Death (Month, Day, Year): January 8 2001

3. Time of Death: 5:33 am

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 219-18-8414

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 8, 1925

9. Birthplace (State or Foreign Country): Ellicott City,

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8801 Autumn Hill Dr.

10f. Zip Code: 21043

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☐ No. If Yes, Give Year or Dates: 1943 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Butcher

16b. Kind of Business/Industry: Acme & Giant Foods

17. Father's Name (First, Middle, Last): John W. Werking, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Marie V. Bazzell

19a. Informant's Name/Relationship (Type, Print): Mrs. Mildred N. Werking

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8801 Autumn Hill Dr. Ellicott City, Maryland 21043

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Cemetery

Date: 01/11/01

20c. Location - City or Town, State: Ellicott City, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

b. MI / P.E.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CAD — Months

Due to (or as a consequence of):

d. AF — 11

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D44315

29d. Date signed (Month, Day, Year): 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VINCENZO GRIPPO SAINT AGNES HOSPITAL 900 CATON AVENUE

State Registrar

31. Date filed (Month, Day, Year): 1/8/01

32. Registrar's Signature: JAN 16 2001 Geneva G Sparks

WERKING, John

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0158-027

JEFFERY WILLIAMS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00684

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: **Jeffrey Yookong Williams**

2. Date of Death — Month: JANUARY Day: 9 Year: 2001

3. Time of Death: 7:10P.M.

4a. Facility Name *(If not institution, give street and number)*: 7913 ROSEWAY

4b. City, Town, or Location of Death: SAVAGE

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 231-49-8420

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 14 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 30, 1986

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Jessup

10d. Inside City Limits: 1☐ Yes 2☐ No — X

10e. Street and Number: 7913 Red Rose Way

10f. Zip Code: 20794

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced — X

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No — X — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student

16b. Kind of Business/Industry: Patuxent Valley Middle

17. Father's Name *(First, Middle, Last)*: James Arthur Williams

18. Mother's Name *(First, Middle, Maiden Surname)*: Orawan Yookong

19a. Informent's Name/Relationship *(Type, Print)*: Mr. James Williams

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7913 Red Rose Way Jessup, Maryland 20794

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)* — X

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rosewood Memorial Park

Date: 01/14/01

20c. Location - City or Town, State: Virginia Beach, VA

21. Signature of Funeral Service Licensee: Robert Slack 10033

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) — e. Hanging

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No — X

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* SCENE — X

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: Found 1-9-01

28b. Time of Injury: Found 1900 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: home

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 7913 Roseway Savage, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis Chutemo

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JANUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dennis Chutemo 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00685

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Latimer Gorsuch Young
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 11:13pP
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 220-01-1207
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep 1, 1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: —
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 124B East Melrose Avenue
10f. Zip Code: 21212
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pediatrician
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Cyrus Clifton Young
18. Mother's Name (First, Middle, Maiden Surname): Edith Margaret Gorsuch

19a. Informant's Name/Relationship (Type, Print): Mrs. Jean Young Butler
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 Elder Road, Hydes, MD 21082

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Chesapeake Crematory | Date: Jan 16 2001
20c. Location - City or Town, State: Beltsville, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Adult Respiratory Distress Syndrome	2 days
Due to (or as a consequence of):	Pancreatitis	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Chemical Pneumonitis from Aspiration	2 days
c. Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure, Atrial Fibillation, Alcphol Abuse

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MEDICAL Doctor
29c. License number: AT 2438946
29d. Date signed (Month, Day, Year): JANUARY 11 2001
30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Dr. John Stratidis M.D. 201 East University Parkway,

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MC 1ST

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00686

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JANET G. YEARLEY
2. Date of Death Month Day Year: JANUARY 12, 2001
3. Time of Death: 12:15PM
4a. Facility Name *(If not Institution, give street and number)*: NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-46-3256
6. Sex: 1☐ M XX F
7. Age *(In yrs. last birthday)*: 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 05-20-1919
9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: SYKESVILLE
10d. Inside City Limits: 1☐ Yes XX No
10e. Street and Number: 710 OBRECHT ROAD
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed XX Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2 YEARS
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: ALEXANDER GROSSET
18. Mother's Name *(First, Middle, Maiden Surname)*: FRANCES STARCKS

19a. Informant's Name/Relationship *(Type, Print)*: ALEXANDER G.YEARLEY (SON)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 31 MARTIN STREET,REHOBETH BEACH,DE.,19971

20a. Method of Disposition: 1☐ Burial XX Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GREEN MOUNT CREMATORY
Date: 1-15
20c. Location - City or Town, State: BALTIMORE,MD.,21202

21. Signature of Funeral Service Licensee: R. H. Ruth
22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause *on* each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY EMBOLISM — DAYS

Due to (or as a consequence of):
b. DEEP VEIN THROMBOSIS — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequenca of):
c.

Due to (or es e consequenca of):
d.

Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.: BREAST CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably XX Unknown

24a. Was an autopsy performed? 1☐ Yes XX No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes XX No
26. Place of Death *(Check only one)*: Hospital: XX Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: XX Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: XX **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Avverahalli
29c. License number: D 42723
29d. Date signed *(Month, Day, Year)*: JANUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AVVERAHALLI M. HARISH,M.D.,NORTHWEST HOSPITAL CENTER,RANDALLSTOWN,MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00687

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDDIE THOMAS YOUNG

2. Date of Death: Month: January Day: 12 Year: 2001

3. Time of Death: 8:45 A.M.

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 220-36-5008

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08 27 1941

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL CO.

10c. City, Town or Location:

10d. Inside City Limits: 1 [ ] Yes 2 [X] No XX

10a. Street and Number: 5901 BELLE GROVE ROAD

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No XX If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No XX Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician

16b. Kind of Business/Industry: Salon Owner

17. Father's Name (First, Middle, Last): DAVID YOUNG

18. Mother's Name (First, Middle, Maiden Surname): FRANCES MARTIN

19a. Informant's Name/Relationship (Type, Print): FRANCES YOUNG/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 125 Bishop Avenue, Baltimore, Maryland 21225

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY

Date: 1/18/01

20c. Location - City or Town, State: BROOKLYN, MARYLAND

21. Signature of Funeral Service Licensee: Charles N. Powell

22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY FUNERAL HOME, 1206 W. NORTH AVENUE, BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE PULMONARY EDEMA

Due to (or as a consequence of):

b. ACUTE RENAL FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. GRAM POSITIVE SEPTICEMIA

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43977

29d. Date signed (Month, Day, Year): January 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Appkin Obstetrics · 301 Hospital Drive, Glen Burnie · MD. 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [illegible] Sparks

DHMH 16 Rev 6/95

ORIGINAL

Young Freddie

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00688

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SIDNEY ZEMIL
2. Date of Death Month / Day / Year: January 12, 2001
3. Time of Death: 4:25 A
4a. Facility Name *(If not institution, give street and number)*: LEVINDALE HEBREW HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-18-8756
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 29, 1915
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3026 FALLSTAFF ROAD #F
10f. Zip Code: 21209
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALESMAN
16b. Kind of Business/Industry: RETAIL

17. Father's Name *(First, Middle, Last)*: MAX ZEMIL
18. Mother's Name *(First, Middle, Maiden Surname)*: SYLVIA KRUGER

19a. Informant's Name/Relationship *(Type, Print)*: JACK ZEMIL / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2208 SUGARCONE ROAD - BALTIMORE, MD 21209

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: HEBREW YOUNG MEN CEMETERY
Date: 1/14/01
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: Robert [illegible]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Debra [illegible]
29c. License number: D23767
29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Debra S. Wertheimer MD 2434 W. Belvedere Ave, Balto. MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

ZEMIL, SIDNEY

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00689

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWRENCE G. ABE

2. Date of Death (Month, Day, Year): January 4 2001

3. Time of Death: 20:50

4a. Facility Name (If not institution, give street and number): LIONS MANOR NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 705-09-7035

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 17, 1913

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: WV

10b. County: MINERAL

10c. City, Town or Location: RIDGELEY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: R.R. 1, BOX 173

10f. Zip Code: 26753

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTER

16b. Kind of Business/Industry: CARPENTRY

17. Father's Name (First, Middle, Last): WILLIAM ABE

18. Mother's Name (First, Middle, Maiden Surname): NETTIE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): ARLETTA ABE / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5408 S. PRESTONWOOD AVE., RICHMOND, VA 23234

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): WVU ANATOMY BOARD

Date: 01/05/2001

20c. Location - City or Town, State: MORGANTOWN, WV

21. Signature of Funeral Service Licensee: ▶ Wendy D. Upchurch

22. Name and Address of Facility: WV ANATOMY BOARD, P.O. BOX 9128 - MORGANTOWN, WV 26506

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Edema — 1 hr.

Due to (or as a consequence of):

b. Acute M.I — few hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

C.O.P.D, C.V.A. S/P Acute M.I Diabetis Mellitus!

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ V.A. Ranjithan

29c. License number: D19750

29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VA Ranjithan MD, Lions Manor Nursing Home, Seton Drive Extended, Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 05 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Abe, Lawrence
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00690

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE FRANCIS ARCHAMBAULT, SR.

2. Date of Death: Month JAN Day 1 Year 2001

3. Time of Death: 3:00 PM

4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 005-18-4937

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APRIL 29, 1909

9. Birthplace *(State or Foreign Country)*: MASSACHUSETTS

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: BETHESDA

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5916 MELVERN DRIVE

10f. Zip Code: 20817

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PUBLIC HEALTH OFFICER LAWYER & PHARMACIST

16b. Kind of Business/Industry: U.S. PUBLIC HEALTH SERVICE

17. Father's Name *(First, Middle, Last)*: GEORGE CHARLES ARCHAMBAULT

18. Mother's Name *(First, Middle, Maiden Surname)*: CATHERINE V. MAYETTE

19a. Informant's Name/Relationship *(Type, Print)*: WILLIAM H. ARCHAMBAULT/ SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 525 VILLAGE WOODS EARLYSVILLE, VIRGINIA 22936

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GATE OF HEAVEN CEMETERY

Date: JANUARY 5, 2001

20c. Location - City or Town, State: SILVER SPRING, MARYLAND

21. Signature of Funeral Service Licensee: M00335

22. Name and Address of Facility: ROBERT A. PUMPHREY FUNERAL HOME/ BETHESDA-CHEVY CHASE, INC, 7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)

e. PNEUMONIA

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Plece of Deeth *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of *my* knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end manner steted.

29b. Signature and title of certifier: MD

29c. License number: 97-01454 (NC)

29d. Dete signed *(Month, Dey, Year)*: 01/02/01

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): J.V.LAWLER, LT, MC, USNR

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 03 2001

32. Registrer's Signature: Bonnie B. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

G.F

25 +1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00691

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Carlton Adkins

2. Date of Death — Month: JANUARY Day: 08 Year: 2001

3. Time of Death: 8:25PM

4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 231-12-6251

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Aug.17,1920

9. Birthplace (State or Foreign Country): Virginia

Usual Residance of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 11904 Gordon Avenue

10f. Zip Coda: 20705

10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar In U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas: 1945-1946

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada compiated) — Elementary/Secondary (0-12): 12 — Collega (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Yardmaster

16b. Kind of Business/Industry: Railroad

17. Fathar's Nama (First, Middla, Last): Charles Adkins

18. Mothar's Name (First, Middle, Meiden Surnema): Delia Rigney

19a. Informant's Name/Ralationship (Type, Print): Roger Craig Adkins - son

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 8647 Stonecutter Road Columbia, Maryland 21045

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Piaca of Disposition (Nama of cematary, crematory or othar place): Fort Lincoln Cemetery — Data: 1/16/2001

20c. Location - City or Town, Stata: Brentwood, Maryland

21. Signatura of Funaral Sarvica Licensee: ▶ Matthew A Brown

22. Nama and Addrass of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach line. — Approximate Intarval Batween Onset and Death

Immediata Causa (Final diseasa or condition rasulting in death)
a. Coriact arrest
Dua to (or as a consequance of):
b. Pericardial effusion Bloody.
Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last
Dua to (or as a consequence of):
c. Pericarditis
Dua to (or as a consequanca of):
d. Enlarged Heart - congestive failar

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.
Peripheral edema.
Renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yas 2 [ ] No

26. Place of Death (Check only one) — Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Rasidanca 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one) — 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, deeth occurred at tha tima, data and placa, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of certifiar: ▶ Bahram Erfan

29c. Licansa number: D02236

29d. Data signed (Month, Day, Year): 1-8-01

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Bahram Erfan MD 6510 Kenilworth Ave Suite 2500 Riverdale Md 20737

State Registrar

31. Data filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signatura: ▶ G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 25 26,27,28a-f per me G792 2/2/01 yf

Certificate of Death

Reg. No. 2001 00692

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN MORRIS ALE

2. Date of Death (Month, Dey, Year): JAN. 7, 2001

3. Time of Death: 3:30 PM

4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 148-22-7485

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 25, 1932

9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 14510 HOMECREST RD. #2014

10f. Zip Code: 20906

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRINTER

16b. Kind of Business/Industry: PRINTING

17. Father's Name (First, Middle, Last): MORRIS ALE

18. Mother's Name (First, Middle, Maiden Surname): MARY VIVIAN TOY

19a. Informant's Name/Relationship (Type, Print): CHERYL ALE AUXIER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 44 WINTERBERRY CT., HUNT VALLEY, MD. 21030

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY

Date: 1/9/01

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers M00091

22. Name and Address of Facility: 5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES,P.A., RIVERDALE, MD.20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE INTRACRANIAL HEMORRHAGE — 5 DAYS

Due to (or as a consequence of):

Stephen L Nadig CERTIFICATION APPROVED BY MEDICAL EXAMINER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, ATRIAL FIBRILLATION

CHRONIC OBSTRUCTIVE LUNG DISEASE

MULTIINFARCT DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 1/2/01

28b. Time of Injury: 10:30 A M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Giants Market

28f. Location (Street and Number or Rural Route Number, City or Town, State) Montgomery County, Md 2211 Bel Pre Road

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martin C Shargel D

29c. License number: D08944

29d. Date signed (Month, Day, Year): JAN. 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARTIN C. SHARGEL, M.D., 3720 FARRAGUT AVE., KENSINGTON, MD. 20895

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00693

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gaetano Amatucci

2. Date of Death Month Day Year: January 6, 2001

3. Time of Death: 0720

4a. Facility Name *(If not institution, give street and number)*: 4912 Brandon Lane

4b. City, Town, or Location of Death: Beltsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-44-5970

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 1, 1904

9. Birthplace *(State or Foreign Country)*: Italy

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4912 Brandon Lane

10f. Zip Code: 20705

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tool Shop Foreman

16b. Kind of Business/Industry: Automotive Sales

17. Father's Name *(First, Middle, Last)*: Gaetano Amatucci

18. Mother's Name *(First, Middle, Maiden Surname)*: Teresa (Unobtainable)

19a. Informant's Name/Relationship *(Type, Print)*: Carmin Amatucci - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4912 Brandon Lane, Beltsville, MD 20705

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery | Date: 1-9-01

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [/] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [/] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [/] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [/] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DO

29c. License number: H0055927

29d. Date signed *(Month, Day, Year)*: January 8 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00694

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alfred Joseph Arsenault

2. Date of Death Month Day Year: January 11, 2001

3. Time of Death: 3:05 AM

4a Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 019-07-0582

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 25, 1917

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 740 Quince Orchard Blvd. Apt 102

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Vice President/Construction

16b. Kind of Business/Industry: Marriott Corporation

17. Father's Name *(First, Middle, Last)*: Frank Arsenault

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Anne Chaison

19a. Informant's Name/Relationship *(Type, Print)*: Daniel F. Arsenault/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: #9 Michele Court, Gaithersburg, Maryland 20878

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: St. Cecelia's Cemetery

Date: Jan. 15, 2001

20c. Location - City or Town, State: Leominster, Massachusetts

21. Signature of Funeral Service Licensee: [signature]

M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. SEPSIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: H51280

29d. Date signed *(Month, Day, Year)*: 1-11-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anushiravan Dadgar, M.D. 13219 Executive Park Terrace, Germantown, Maryland 20874

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: [signature] S. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend item 2 per co 8849 11-7-05 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00695

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Janice Juanita Buckley
2. Date of Death Month Day Year: January 5, 2001
3. Time of Death: 05:45
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217 ~~216~~-46-5712
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 53 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 19, 1947
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residance of Decadent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 1909 Rockland Avenue
10f. Zip Code: 20851
10g. Citizan of What Country?: United States of America

11. Merital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Frame Attendant
16b. Kind of Businass/Industry: Telephone Company

17. Father's Nema *(First, Middle, Last)*: Robert Joseph Bugos
18. Mothar's Nama *(First, Middla, Maiden Surname)*: Juanita Slavin

19a. Informent's Name/Ralationship *(Type, Print)*: Malcom N. Buckley / husband
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 1909 Rockland Avenue, Rockville, Maryland 20851

20a. Mathod of Disposition: 1☐ Burial 2☒ Crametion 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, crametory or other place)*: Metropolitan Crematory — Date: Jan. 8, 2001
20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signatura of Funaral Servica Licensee: John E. Barber
22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that ceused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina. — Approximata Interval Between Onsat and Daath

Immediata Cause (Finel disaasa or condition resulting in daath)
a. Sepsis — Days

Dua to (or as a consaquanca of):
b. Neutropenia — Days

Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaasa or injury that initiated events resulting in death) Last
Due to (or es e consaquanca of):
c. Metastatic Ovarian Cancer — Years

Due to (or es e consaquanca of):
d.

Part II. **Other significant conditiona** contributing to death but not rasulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was cesa rafarred to medical examinar? 1☐ Yes 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined

28a. Deta of Injury *(Month, Day Year)* — 28b. Tima of Injury — 28c. Injury at Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and placa, and due to the ceusa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, data and placa, and due to the ceusa(s) and manner stated.

29b. Signature and title of cartifier: Joseph A Ball md
29c. Licansa number: D53917
29d. Date signed *(Month, Day, Year)*: JANUARY 5 2001

30. Nama and address of person who completed ceusa of daath (Item 23a) (Type, Print): Joseph A. Ball, M.D., 16620 Frederick Road., Suite 213, Gaithersburg, Maryland 20877

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 0 8 2001
32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

GF

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00696

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Tamae Miyashiro Brockman
2. Data of Death Month / Day / Yaar: Jan 5 2001
3. Tima of Death: 1905
4a. Facility Nema *(If not institution, giva street and number)*: 3818 Dunsmane Dr
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 249-05-7586
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Yeer)*: July 1, 1923
9. Birthplace *(State or Foreign Country)*: Japan

Usual Rasidance of Decedent

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Straat and Numbar: 3818 Dunsinane Drive
10f. Zip Coda: 20906
10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Nevar Married 2☐ Marriad 3☒ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* Asian

15. Decedant's Education *(Specify only highast grade completed)*: Elamentary/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: Hairdresser
16b. Kind of Business/Industry: Cosmetology

17. Father's Nama *(First, Middla, Last)*: Unknown Miyasiro
18. Mothar's Name *(First, Middla, Maidan Surneme)*: Unknown

19a. Informant's Name/Ralationship *(Type, Print)*: Robert Wallace Brockman (brother-in-law)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 1631 Keith Valley Road Charlottesville, Virginia 22901

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nema of cematary, cremetory or othar place)*: Metropolitan Crematory
Data: Jan.11, 2001
20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signeture of Funaral Sarvice Licensee: James E Dooley
22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part I. Entar tha disaesa, or complications that causad tha daath. Do not enter the moda of dying, such as cardiac or respiratory errest, shock, or heart feilura. List only ona causa on aach lina.

Approximeta Intarval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in daath)
a. Probale myocardial infarction DME
Dua to (or as a consequance of):
b.
Dua to (or as a consequance of):
c.
Due to (or as a consequanca of):
d.

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or injury that initiated evants rasulting in daath) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings aveilable prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa refarrad to medical examiner? 1☒ Yas 2☐ No
26. Placa of Death *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Sulcida 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined
28a. Data of injury *(Month, Day Yeer)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Piece of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To tha best of my knowledge, deeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☒ **Medical Examiner**: On tha basis of examinetion and/or invastigation, in my opinion, daath occurrad at tha tima, data and place, and due to tha cause(s) and manner stated.
29b. Signature and title of certifier: [illegible] MD OME
29c. Licansa number: D00726
29d. Deta signed *(Month, Day, Year)*: Jan 5 2001
30. Nama and address of parson who completed causa of daath (Item 23a) (Type, Print): 2101 Medical Park Dr IRA N BREWER, MD OME Silver Spring MD 20902

State Registrar

31. Data filed *(Month, Day, Yaer)*: JAN 11 2001
32. Ragistrar's Signatura: [illegible] G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00697

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alban Garnett Breen
2. Date of Death Month Day Year: January 7, 2001
3. Time of Death: 4:32 AM
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-36-6292
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 70 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: Feb. 12, 1930
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. Stete: Md.
10b. County: Prince George
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1801 Metzerott Road
10f. Zip Code: 20783
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1949-1952
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Reca - American Indien, Blеck, White, etc. *Specify:* white

15. Decedant's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / Collage (1-4or 5+): 4
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Sales
16b. Kind of Business/Industry: Self-employed

17. Father's Name *(First, Middle, Last)*: Leo A. Breen
18. Mothar's Neme *(First, Middle, Maidan Surname)*: Myrtle Scates

19a. Informant's Name/Reletionship *(Type, Print)*: Kathleen C. Zepp/daughter
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 6516 Delia Drive, Alexandria, Va. 22310

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Dete: Jan. 9, 2001
20c. Location - City or Town, State: Alexandria, Va.

21. Signeture of Funerel Service Licensee: James E. DeVol
22. Name end Address of Fecility: DeVol Funeral Home, 2222 Wisconsin Ave., NW., Washington, DC 20007

Physician /Medical Examiner

23a. PART I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR Disease — 4 years

Dua to (or as e consequance of):

Sequentially list conditions, if any, leading to immediete causa. Entar Underlying Cause (Diseasa or injury thet initieted events resulting in death) Last:
b.
Dua to (or as a consequanca of):
c.
Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: DIABETES MELITUS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Was case refarred to medical examiner? 1 ☐ Yas 2 ☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Mannar of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding investigation 6 ☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invastigetion, in my opinion, death occurred et the tima, data and place, and dua to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: Richard E. Wrenn MD
29c. Licanse number: D01852
29d. Dete signed *(Month, Day, Year)*: JANUARY 9 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A. DEVORE MD 4203 QUEENSBURY RD HYATTSVILLE MD 20781

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00698

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Boyd

2. Date of Death: Month Jan. Day 8 Year 2001

3. Time of Death: 12:55 AM

4a. Facility Name (If not institution, give street and number): Manor Care Potomac

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 139-05-8620

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 4 1905

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 20 O'Neill Drive

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Forklift Operator

16b. Kind of Business/Industry: Main Factory

17. Father's Name (First, Middle, Last): Isiah Boyd

18. Mother's Name (First, Middle, Meiden Sumeme): Cleo Dunn

19a. Informant's Name/Relationship (Type, Print): Luerether Boyd/Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 68 State Court, Gaithersburg, MD 20877

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory Inc

Date: Jan 8 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Beverly L Herbotte

22. Name and Address of Facility: Rapp Funeral & Cremation Services
Stephen D. Lohrmann, 933 Gist Ave.
Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident — Years

Due to (or as a consequence of):
b. Hypertension — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Benign Prostate Hypertrophy — Years

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were sutopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Rao MD

29c. License number: D35792

29d. Dete signed (Month, Day, Year): Jan. 08, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Swaroop G. Rao, M.D., Ph.D. 50 W. Edmonston Drive, #504 Rockville, MD 20852

State Registrar

31. Date filed (Month, Dey, Year): JAN 0 9 2001

32. Registrar's Signature: Renee B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00699

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHIRLEY A. BOWKER

2. Date of Death: Month JAN. Day 8, Year 2001

3. Time of Death: 9:13 AM

4a Facility Name *(If not institution, give street and number)*: LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death: LAUREL

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 275-20-3858

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 10,1925

9. Birthplace *(State or Foreign Country)*: OHIO

Usual Residence of Decedent

10a. Stete: MD.

10b. County: PRINCE GEORGES

10c. City, Town or Location: LAUREL

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3396 YELLOW SPRING SOUTH

10f. Zip Code: 20724

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- tf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: HERBERT ROOD

18. Mother's Name *(First, Middle, Maiden Surname)*: EVELYN RANDALL

19e. Informant's Name/Relationship *(Type, Print)*: CONSTANCE KIMSEY/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: SAME AS ITEM #10

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: CHAMBERS CREMATORY

Date: 1/9/01

20c. Location - City or Town, Stete: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers

M00091

22. Name and Address of Fecility: CHAMBERS FUNERAL HOMES,P.A., 5801 CLEVELAND AVE. RIVERDALE, MD.20737

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

tmmediate Cause (Final disease or condition resulting In deeth): a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 10 YRS.

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due fo (or es e consequence of):

d.

Part tl. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Pert I.: HYPERTENSION, AORTIC STENOSIS, COR PULMONALE

23b. Dtd tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of tnjury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Margolis MD

29c. License number: D25430

29d. Date signed *(Month, Day, Year)*: 1/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John MARGOLIS 13952 Baltimore AVE Laurel, MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: Irene G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00700

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DUANE UBBE BEVING

2. Date of Death: Month JANUARY Day 5 Year 2001

3. Time of Death: 10:30 PM

4a. Facility Name (If not institution, give street and number): National Institute of Health

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 485-46-5090

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 15, 1931

9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 1209 Harding Lane

10f. Zip Code: 20905

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 1956-1985

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Military

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Arthur Beving

18. Mother's Name (First, Middle, Maiden Surname): Evelyn Schultz

19a. Informant's Name/Relationship (Type, Print): Adriana Beving / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1209 Harding Lane, Silver Spring, Maryland 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.

Date: Unk.

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: ▶ Robert J. DeMay

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Non Hodgkin's Lymphoma — Approximate Interval: 5 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert J. Behrens MD

29c. License number: D54239

29d. Date signed (Month, Day, Year): January, 06, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT J. BEHRENS 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

30+1

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 007011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY C. BEVERLY

2. Date of Death Month Day Year: JANUARY 2, 2001

3. Time of Death: 10:30 PM

4a. Facility Name (If not institution, give street and number): 9534 Angelina Circle

4b. City, Town, or Location of Death: Columbia

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 220-34-4837

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June13,1919

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9534 Angelina Circle

10f. Zip Code: 21045

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Thomas Jackson

18. Mother's Name (First, Middle, Maiden Surname): Emma Smith

19a. Informant's Name/Relationship (Type, Print): Edna M. Ball (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6581 Robin Song, Columbia, MD 21045

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Ash Memorial Cem. | Date: 1/8/01

20c. Location - City or Town, State: Sandy Spring, MD

21. Signature of Funeral Service Licensee: Bruce R. Snowden Jr

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

GF

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — Days

Due to (or as a consequence of):
b. pressure sores — Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeff Katz MD

29c. License number: D36786

29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFF KATZ, M.D. 7061 Deepage Dr Suite 104, Columbia Md 21045

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00702

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARTHA L. BERMAN
2. Date of Death (Month, Day, Year): JAN. 5 2001
3. Time of Death: 7:00 AM
4a. Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-56-5128
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 23, 1905
9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: TEMPLE HILLS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3045 BRINKLEY RD. #102
10f. Zip Code: 20748
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: PHILIP LIEBOWITZ
18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA ROMANOFSKY

19a. Informant's Name/Relationship *(Type, Print)*: EDYTHE MACCHIAVELLO/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4400 EAST-WEST HWY. BETHESDA, MD 20814

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: JUDEAN MEMORIAL GARDENS | Date: 01/08 2001
20c. Location - City or Town, State: OLNEY, MD

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA, BILATERAL — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ D. Patel M.D.
29c. License number: D 18084
29d. Date signed *(Month, Day, Year)*: JANUARY 05, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00703

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
Naomi	S	Bender	January 1, 2001	3:09 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
506 Midland Road	Silver Spring,	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
189 07 2876	1☒ M 2☐ F	81 Yrs.					Sept. 17, 1919	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
506 Midland Road	20904	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Straley	Elsie Brown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward S. Bender / Son	6524 78th St., Cabin John, Maryland 20818

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory	01/04/01	Beltsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Adam J. Donnell	Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

G.F.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory failure	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. COPD	
	Due to (or as a consequence of):	
	c. Pulmonary embolism	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Ira Tauber MD	D18813	January 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ira Tauber, M.D. 10301 Georgia Avenue, Silver Spring, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 8 2001	▶ Jeanne G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00704

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Wilola Ball

2. Date of Death (Month, Day, Year): January 5, 2001

3. Time of Death: 11:55 pm

4e. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-44-4432

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 23, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3347 Buehler Court

10f. Zip Code: 20832

10g. Citizen of What Country: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Reca - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Orville Ganbin

18. Mother's Name (First, Middle, Maiden Sumame): Susan Snow

19a. Informent's Name/Relationship (Type, Print): Robert Prinz/Nephew

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3347 Buehler Ct., Olney, MD 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, cremetory or other place): Ft. Lincoln Cemetery

Date: 01/09/01

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: ▶ J. Ken Stiles

22. Name and Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

e. SEPSIS

Due to (or es e consequence of):

b. Pneumoma

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anoxic encephalopathy

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homlcide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and pieca, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: ▶

29c. License number: D42403

29d. Date signed (Month, Dey, Year): 1/6/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJ MATHUR 106 Irving Street NW, washington DC 20010

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001

32. Registrar's Signature: ▶ Bernice G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00705

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vera A. Boulavsky
2. Data of Death: Month January Day 2, Year 2001
3. Time of Death: 3:30pm
4a. Facility Name *(If not institution, give street and number)*: 3585 S.Leisure World Blvd.
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-40-5457
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 100 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Sept.15,1900
9. Birthplace *(State or Foreign Country)*: Russia

Usual Residence of Decadant

10a. State: Md
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 3585 S.Leisure World Blvd.
10f. Zip Coda: 20906
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Marriad 3☒ Widowed 4☐ Divorced
12. Was Dacadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Spacify Yas or No- if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Raca - Amarican indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Spacify only highast grada complatad)*: Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Catalogger
16b. Kind of Businass/Industry: Library of Congress

17. Fathar's Nama *(First, Middle, Last)*: Alexander Novikoff
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Natalia Minnin

19a. Informant's Name/Raiationship *(Type, Print)*: Leon Boulavsky/ Son
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 1541 Nova Avenue Capital Heights, Md 20743

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cametary, crematory or othar place)*: Rock Creek Cemetery
Data: 1/04/01
20c. Location - City or Town, Stete: Wash.D.C.

21. Signature of Funaral Sarvica Licensee: Philip D. Rinaldi
22. Nama and Address of Facility: Philip D.Rinaldi Funeral Service 11818 New Hampshire Ave.Silver Spring,Md

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona causa on aach lina.

Approximata Interval Between Onset and Death

Immadiata Causa (Final disaasa or condition rasulting in daath):
a. Endstage Dementia — years
Due to (or as a consequanca of):
Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Diseese or injury that initiated events rasulting in daath) Last
b.
Due to (or as a consequance of):
c.
Dua to (or es a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying causa givan in Part I.: Coronary artery disease, Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabia prior to complation of cause of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☒ Yas 2☐ No
26. Plece of Deeth *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Other: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Othar *(Specify)*
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Sulcida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determinad
28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, date and plece, and due to the cause(s) end manner es steted.
2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the cause(s) and mannar stated.

29b. Signature and tila of certifiar: MD
29c. Licansa number: D43202
29d. Data signed *(Month, Day, Year)*: January 2, 2001

30. Nama and addrass of person who complatad causa of daath (Item 23a) (Type, Print): Cozanne-Blankford MD 3305 North Leisure world Blvd Silver Spring Maryland 20906

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 04 2001
32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00706

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George Benson

2. Date of Death Month Day Year: January 4, 2001

3. Time of Death: 3:55 pm

4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-28-2335

6. Sex: 1 X M 2 F

7. Age *(in yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr 6, 1931

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1 X Yes 2 No

10e. Street and Number: 623 White Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yas 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: superintendent

16b. Kind of Business/Industry: railroad

17. Father's Name *(First, Middle, Last)*: Chester Cecil Benson

18. Mother's Name *(First, Middle, Maiden Surname)*: Lottie I (Bishop)

19a. Informant's Name/Relationship *(Type, Print)*: Mary Benson wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 623 White Avenue;Cumberland MD 21502

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Sunset Memorial Park

Date: 1/08/2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: James J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	1 week
Due to (or as a consequence of):	b. Gangrenous amputation stump, right leg	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure, diabetic nephropathy, cardiomyopathy, anemia

23b. **Did tobacco use contribute to the cause of death?** 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N.A. Ranjithan MD

29c. License number: D19318

29d. Date signed *(Month, Day, Year)*: January 5th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ranjithan, 517 Oldtown Road, Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001

32. Registrar's Signature: B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00707

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DELMAR LLOYD BOSS SR.

2. Date of Death Month / Day / Year: JAN 2 2001

3. Time of Death: 12 45 PM

4a. Facility Name *(If not institution, give street and number)*: 6171 HARMONY ROAD

4b. City, Town, or Location of Death:

4c. County of Death: CAROLINE

Funeral Director

5. Social Security Number: 038-03-2480

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV. 15, 1913

9. Birthplace *(State or Foreign Country)*: RHODE ISLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: CAROLINE

10c. City, Town or Location: PRESTON

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6171 HARMONY ROAD

10f. Zip Code: 21655

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: GRAIN MILL / FARMER

16b. Kind of Business/Industry: FARMER

17. Father's Name *(First, Middle, Last)*: HOWARD C. BOSS

18. Mother's Name *(First, Middle, Maiden Surname)*: DELLA TABOR

19a. Informant's Name/Relationship *(Type, Print)*: ROSE MARIE JOHNSON - DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6171 HARMONY Rd. PRESTON

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: HILLCREST CEMETERY

Date: 01/05/01

20c. Location - City or Town, State: FREDERICKSBURG, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WILLIAMSON FUNERAL HOME, FREDERICKSBURG, MD 21632

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. lung Carcinoma — 9 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D47232

29d. Date signed *(Month, Day, Year)*: 1/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY DeSHIELDS 509 IDLEWILD AVE EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 4 2001

32. Registrar's Signature: [signature] Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00708

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Martha Louise Burnette

2. Data of Death — Month: January Dey: 2, Yaar: 2001

3. Tima of Death: 6:00 PM

4a. Facility Name *(If not Institution, give street end numbar)*: Mariner Health Care Center

4b. City, Town, or Location of Deeth: Kensington

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 422-18-2372

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Feb. 6, 1916

9. Birthplace *(Stete or Foreign Country)*: Alabama

Usuel Residence of Decedent

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11808 Collins Drive

10f. Zip Code: 20876

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indlan, Black, Whita, atc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): — College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Librarian

16b. Kind of Business/Industry: Federal Government

17. Father's Nema *(First, Middle, Last)*: Greene Doswell Burnette

18. Mother's Name *(First, Middle, Maiden Surname)*: Lena Williams

19e. Informant's Name/Relationship *(Type, Print)*: Doris Brannon/Niece

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 11808 Collins Drive, Germantown, Maryland 20876

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Valhalla Cemetery

Dete: 1/6/2001

20c. Location - City or Town, Stata: Midfield, Alabama

21. Signatura of Funeral Service Licensee: Michael A. DeVol

22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GF

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Final diseese or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Causa (Diseese or Injury thet initiated events resulting in death) Lest

b. Atrial Fibrillation

Due to (or es a consequence of):

c. Ischemic Heart Disease

Due to (or as e consequence of):

d. Arteriosclerosis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Osteoarthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performad? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at tha tima, date and piece, end dua to the cause(s) end manner es stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: Robert F. Dyer MD

29c. Licansa number: D 04686

29d. Data signed *(Month, Dey, Year)*: January 3, 2001

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Robert F. Dyer, M.D., 5530 Wisconsin Ave., #540, Chevy Chase, MD. 20815

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 05 2001

32. Registrer's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00709

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gladys Cummins

2. Date of Death: Month JAN Day 03 Year 2001

3. Time of Death: 1720

4a. Facility Name (If not Institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 562-03-0050

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 20, 1915

9. Birthplace (State or Foreign Country): New York

Usuet Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 1131 University Blvd., West. # 504

10f. Zip Code: 20902

10g. Citizen of Whet Country?: U. S. A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 Years; Coltege (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Samuel Mishel

18. Mother's Name (First, Middle, Maiden Surname): Anna Israel

19e. Informent's Neme/Reletionship (Type, Print): Ann C. Star - Daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 12810 Teaberry Road, Silver Spring, Md. 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Judean Memorial Gardens

Dete: 1/7/2001

20c. Location - City or Town, Stete: Olney, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Neme end Address of Fecility: Danzansky-Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, Maryland 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 10

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Intervet Between Onset end Death

Immediete Cause (Final disease or condition resulting in death)

e. PERFORATED VISCUS — 1 WEEK

Due to (or es e consequence of):

b. RIGHT BRONCHOPNEUMONIA — 2 WEEKS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest

Due to (or es a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

MORBID OBESITY

ACUTE RENAL FAILURE

ARTERIAL HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopay findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannes of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D 51096

29d. Dete signed (Month, Dey, Year): 01/03/2001

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): DR. ROBERT SMITH M.D. 7610 CARROLL AVENUE#270 TAKOMA PARK, MD 20912

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrer's Signeture: ▶ B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

20

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00710

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert W. Cooper
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 19:30
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-38-3676
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 31, 1938
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 12208 Lemar Court
10f. Zip Code: 20904
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): ; College (1-4or 5+): 4
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Computer Engineer
16b. Kind of Business/Industry: Government Contractor

17. Fathar's Nama (First, Middle, Last): Donald H. Cooper
18. Mother's Name (First, Middle, Maiden Surneme): Evelyn Gregory

19e. Informant's Name/Relationship (Type, Print): Freia N. Cooper / Wife
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code): 12208 Lemar Court, Silver Spring, Maryland 20904

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or othar piece): Metropolitan Crematory
Date: January 10, 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Servica Licensee: John C. Parker
22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onsat end Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia - Viral	5 days
Due to (or as e consequence of): b.	Squamous Cell Lung Cancer	2 months
Sequantially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last — Due to (or as a consequence of): c.		
Due to (or es e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings available prior to completion of causa of death? 1 ☐ Yea 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Plece of Deeth (Check only one): Hospitel: 1 ☒ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Daath: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not ba determined
28a. Data of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at tha time, dete and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Philip G. Henjum, MD
29c. Licensa number: D35045
29d. Date signed (Month, Day, Year): January 5, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Philip G. Henjum, MD 3416 Olandwood Court #204 Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pagas 1 end 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mentel Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00711

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eloise M. Agger Collins

2. Date of Death (Month, Day, Year): January 6, 2001

3. Time of Death: 12:25 AM

4a. Facility Name *(If not institution, give street and number)*: 8306 Melody Court

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 479-24-0660

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 22, 1927

9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8306 Melody Court

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Psychoanalyst

16b. Kind of Business/Industry: Private Practice

17. Father's Name *(First, Middle, Last)*: James Moore

18. Mother's Name *(First, Middle, Maiden Surname)*: Beatrice Weissenburger

19a. Informant's Name/Relationship *(Type, Print)*: Robert J. Collins/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8306 Melody Court, Bethesda, Maryland 20817

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.

Date: January 10, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M01126

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — 3 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Non Small Cell Lung Cancer — 18 Months

Due to (or as a consequence of):

c. Pleural Effusions — 18 Months

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: MD050637

29d. Date signed *(Month, Day, Year)*: January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shakun M. Malik, M.D. 106 Irving Street, N.W. #420, Washington, D.C. 20010

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 00712

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN B. COLBURN
2. Date of Death (Month, Day, Year): JANUARY 5, 2001
3. Time of Death: 10:17AM
4a. Facility Name *(If not institution, give street and number)*: Fairland Nursing Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 054-26-5992
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 2,1932
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes [X] No
10e. Street and Number: 14000 Castle Blvd., #111
10f. Zip Coda: 20904
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Yaar or Datas: 51-54
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yes [X] No *Specify:*
14. Race - Amarican Indian, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12th; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Receiving Clerk
16b. Kind of Business/Industry: Washington Adventist Hosp.

17. Father's Nama *(First, Middle, Last)*: James E. Colburn
18. Mother's Nama *(First, Middle, Maiden Sumame)*: Anna Campbell

19a. Informant's Name/Ralationship *(Type, Print)*: Eliece B. Colburn (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14000 Castle Blvd., #111, Silver Spring,MD 20904

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Name of cametery, crematory or other placa)*: Gate of Heaven Cem.
Data: 1/8/01
20c. Location - City or Town, Steta: Silver Spring,MD

21. Signature of Funaral Service Licensee: George R. Snowden
22. Nama and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications thet caused tha deeth. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Intarval Batween Onset and Death

Immediete Ceuse (Final diseasa or condition resulting in deeth): a. PNEUMONIA — DAYS

Dua to (or es a consequence of):

Sequentially list conditions, if sny, leading to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last:
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: MULTIPLE CEREBROVASCULAR ACCIDENTS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa raferred to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only one)*: Hospitel: 1 [ ] Inpetiant 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [X] Nursing Homa 5 [ ] Rasidence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, streat, fectory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Cartifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, deeth occurred at tha tima, data and place, and dua to the cause(s) and mennar as stated. 2 [ ] **Medical Examiner:** On tha basis of examinetion and/or investigation, in my opinion, daath occurred at the time, date end plece, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Luis A Casas MD
29c. License number: D24997
29d. Data signed *(Month, Day, Year)*: 1/5/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): LUIS A. CASAS MD 8317 CHERRY LANE, LAUREL, MD 20707

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00713

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William F. Clark

2. Date of Death Month: 01 Day: 9 Year: 2001

3. Time of Death: 6 30 AM

4a. Facility Name (If not institution, give street and number): University of MD Med Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 577-44-4685

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 30 1934

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4806 Naples Ave.

10f. Zip Code: 20705

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Navar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Year or Dates: 1950-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Officer

16b. Kind of Business/Industry: Government DC

17. Father's Name (First, Middle, Last): Alfred Joseph Clark

18. Mother's Name (First, Middle, Maiden Surneme): Alice Street

19a. Informant's Name/Reletionship (Type, Print): Alfred H. Clark/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 4806 Naples Ave. Beltsville, MD 20705

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Inc

Date: Jan 12 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensed: Beverly L. Hallette

22. Name and Address of Facility: Rapp Funeral & Cremation Service, Stephen D. Lohrmann, 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Uremia from end stage Renal Dis — 1 wk

Due to (or as a consequence of):

b. Atrial fibrillation from Acute Myocardial Infarct — 2 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Retroperitoneal Bleed

Cholecystitis

23b. Did tobacco use contribute to the causs of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Mennar of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and piace, and due to tha cause(s) and manner stated.

29b. Signatura and title of certifier: Horja Uribe, MD Jorge Uribe M.D. Ph.D.

29c. Licensa number: P14654

29d. Date signed (Month, Day, Year): 1/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Horja Uribe, MD University of MD Medical Center 22 S. Greene St

State Registrar

31. Date filed (Month, Dey, Year): JAN 12 2001

32. Registrar's Signature: Helen B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

15 + 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00714

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Leroy Coleman
2. Date of Death (Month, Day, Year): January 2, 2001
3. Time of Death: 11:45P.M
4a. Facility Name (If not institution, give street and number): Moran Manor Nursing Home
4b. City, Town, or Location of Death: Westernport
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-18-2000
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb.19,1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Lonaconing
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 120 Jackson Street
10f. Zip Code: 21539
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Labor
16b. Kind of Business/Industry: construction-coal

17. Father's Name (First, Middle, Last): Bruce Coleman
18. Mother's Name (First, Middle, Maiden Surname): Isabela Johnson

19a. Informant's Name/Relationship (Type, Print): Tommy Coleman-Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): HC 85 Box 59A,Fisher,W.V. 26818

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Laurel Hill Cemetery | Date: Jan.4, 2001
20c. Location - City or Town, State: Moscow Mills,Md.

21. Signature of Funeral Service Licensee: ▶ Jane E. McKee
22. Name and Address of Facility: Eichhorn-McKenzie Funeral Home P.A. Lonaconing,Md. 21539

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SUDDEN CARDIAC DEATH	1 DAY
Due to (or as a consequence of): b.	CORONARY ARTERY DISEASE	ABOUT 5 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Chronic Obstructive Lung disease
Aortic Valve Stenosis Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ H Sidhu
29c. License number: D26907
29d. Data signed (Month, Day, Year): JANUARY 03,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit S. Sidhu 925 Bishop Walsh Road, Cumberland, Maryland 21502

State Registrar

31. Data filed (Month, Day, Year): JAN 04 2001
32. Registrar's Signature: ▶ Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00715

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mabel Elizabeth Curtis

2. Date of Death Month Day Year: January 1, 2001

3. Time of Death: 5:30AM

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-74-7537

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: September 27,1902

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Montgomery Village

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 18700 Walker Choice Rd. #420

10f. Zip Code: 20886

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John T. Oden

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Jane Carter

19a. Informant's Name/Relationship *(Type, Print)*: Clyde E. Curtis/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 219 Cedar Avenue, Gaithersburg, Maryland 20877

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park | Date: January 4, 2001

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: M01126

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Atrial Fibrillation

Coronary Artery Sclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D0054566

29d. Date signed *(Month, Day, Year)*: January 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ravi Passi, MD 8609 Second Ave., #404B Silver Spring, MD 20910-3360

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 22a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00716

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Walter Victor Chaplin

2. Date of Death Month Day Year: Jan. 3, 2001

3. Time of Death: 12:35 pm

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 147-28-0346

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 14, 1935

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: VA

10b. County: Accomac

10c. City, Town or Location: Greenbackville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2598 Buccaneer Blvd

10f. Zip Code: 23356

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Custom House Broker

16b. Kind of Business/Industry: Import / Export

17. Father's Name *(First, Middle, Last)*: Adam Czaplinski

18. Mother's Name *(First, Middle, Maiden Surname)*: Eva Zalewski

19a. Informant's Name/Relationship *(Type, Print)*: Lucy Bates Adler Chaplin / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 220 Margate Rd., Lutherville, MD 21093

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory, Inc.

Date: 1/6/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ [signature] H00980

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Duodenal Adenocarcinoma — 4 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] Anthony Riley, MD

29c. License number: D25205

29d. Date signed *(Month, Day, Year)*: January 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

GF

8

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00717

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Adelaide Cannady

2. Date of Death (Month, Day, Year): January 2, 2001

3. Time of Death: 10:20 PM

4a. Facility Name (If not institution, give street and number): Montgomery Village Care & Rehabilitation

4b. City, Town, or Location of Death: Montgomery Village

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 141-14-7441

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 24, 1922

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: 845 Flagler Drive

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 845 Flagler Drive

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembler

16b. Kind of Business/Industry: Schick Razor

17. Father's Name (First, Middle, Last): Nathaniel Hinton

18. Mother's Name (First, Middle, Maiden Surname): Pearl Martin

19a. Informent's Name/Ralationship (Type, Print): Janise Cannady Thompson Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 845 Flagler Drive, Gaithersburg, MD 20878

20a. Mathod of Disposition: 1☐ Burial 2☐ Cramation 3☒ Removal from Stata 4☐ Donatlon 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Lakeview Cemetery

Data: 1/4/01

20c. Location - City or Town, Steta: Bridgeport, CT

21. Signature of Funarat Sarvice Licensee: Thomas G. Clyburn

22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on each tine.

Approximata Intarval Batwean Onset and Death

Immediata Causa (Final disease or condition rasulting in death)

a. Stroke — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Diseasa or Injury that Initiated events rasulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

Dementia

Hypertension

Diabetes

23b. Did tobacco usa contributa to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was case referred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D00053828

29d. Data signed (Month, Day, Year): January 3, 2001

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print): Daphna Henkin, M.D. 2309 Shorefield Road, Wheaton, MD 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 04 2001

32. Registrar's Signature: Lenora G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00718

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carolyn M. Duter

2. Date of Death (Month, Day, Year): Jan. 04 2001

3. Time of Death: 1:50 PM

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel General Hospital

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 225-50-7463

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 3 1938

9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13219 Aleutian AVe.

10f. Zip Code: 20851

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 2

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Specialist

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Robert J.C. Maulsby

18. Mother's Name *(First, Middle, Maiden Surneme)*: Helene Ketels

19a. tnformant's Name/Reiationship *(Type, Pnnt)*: Richard Duter/Family Rep.

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 37F Queen Anne Way, Chester, MD 21619

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Ptace of Disposition *(Name of cematery, crematory or other place)*: Chesapeake Crematory Inc

Date: Jan. 10 2001

20c. Location - City or Town, Stata: Beltsville, MD

21. Signature of Funeral Service Licensee: Tammy A. Hoody

22. Nama and Addresa of Facility: Rapp Funeral & Cremation Serv. Stephen D. Lohrmann, 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not anter the moda of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in deeth): a. Pneumonia

Due to (or es a consequence of):

Sequentially list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequenca of):

d.

Part tt. **Other stgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the causa of death? 1☒ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. tnjury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D55187

29d. Data signed *(Month, Day, Year)*: January 4, 2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print): Aimee Yu 600 Ridgely Avenue, Annapolis, MD 21401

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 0 9 2001

32. Registrer's Signeture: Lenore B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00719

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Francis Druckenbrod

2. Date of Death (Month, Day, Year): January 8, 2001

3. Time of Death: 5:45 AM

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 271-01-6034

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 21, 1914

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9921 Silver Brook Drive

10f. Zip Code: 20850

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): +4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Aeronautical Engineer

16b. Kind of Business/Industry: Aircraft Engineering and Manufacturing

17. Father's Name (First, Middle, Last): Lawrence M. Druckenbrod

18. Mother's Name (First, Middle, Maiden Surname): Catherine Schatzeder

19a. Informant's Name/Relationship (Type, Print): Mary Helen Druckenbrod/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9921 Silver Brook Drive, Rockville, Maryland 20850

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakeview Cemetery

Date: January 13, 2001

20c. Location - City or Town, State: Cleveland, Ohio

21. Signature of Funeral Service Licensee: ▶ Will E Brown Jr M00672

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Obstructive Jaundice — Two Weeks

Due to (or as a consequence of):

b. Chronic Renal Failure — Several Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Philip Jay Schwartz M.D.

29c. License number: D24398

29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip Jay Schwartz, M.D., 15225 Shady Grove Road, #302, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Emma B. Soaks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#5 per inf G793 030801 SS

Certificate of Death

Reg. No. 2001 00720

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Heath Douglas

2. Date of Death (Month, Day, Year): January 8, 2001

3. Time of Death: 7:27 PM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: ~~260-50-0366~~ 262-50-0366

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 15, 1906

9. Birthplace (State or Foreign Country): Vermont

Usual Residence of Decedent

10a. State: Florida

10b. County: Pinellas

10c. City, Town or Location: Gulf Port

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2502 York Street S.

10f. Zip Code: 33707

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): –

College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): George Heath

18. Mother's Name (First, Middle, Maiden Surname): Mary Stevens

19a. Informant's Name/Relationship (Type, Print): Barbara D. Wright/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4119 Woodbine Street, Chevy Chase, Maryland 20815

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: January 10, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] 100689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Dehydration

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D56219

29d. Date signed (Month, Day, Year): 1/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Katarzyna Ostrzenska, M.D. 2309 Shorefield Road, Silver Spring, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00721

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Francis Donnelly
2. Date of Death Month Day Year: January 1, 2001
3. Time of Death: 4:00PM
4a. Facility Name *(If not institution, give street and number)*: 10643 MacArthur Boulevard
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-32-2554
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 8, 1924
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10643 MacArthur Blvd.
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Give Year or Dates: World War II
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Publisher
16b. Kind of Business/Industry: Newspaper

17. Father's Name *(First, Middle, Last)*: William F. Donnelly
18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Snelling

19a. Informant's Name/Relationship *(Type, Print)*: Bonnie Benwick/Daughter-in-Law
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10643 MacArthur Blvd., Potomac, Maryland 20854

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.
Date: January 4, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service licensee: David E. Berry M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Prostate Cancer — 2 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D33293
29d. Date signed *(Month, Day, Year)*: January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick P. Smith, M.D. 5401 Western Avenue, N.W., Washington, D.C. 20015-2998

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00722

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn Erma Dennis
2. Date of Death (Month, Day, Year): January 3, 2001
3. Time of Death: 9:15 PM

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 085-14-2707
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 28, 1923
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10622 White Rock Court
10f. Zip Code: 20723
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Resort Hotel

17. Father's Name (First, Middle, Last): Chester L Morrison
18. Mother's Name (First, Middle, Maiden Surname): Laura Bellil

19a. Informant's Name/Relationship (Type, Print): Audrey C. Pfeffer (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10622 White Rock Court Laurel, MD 20723

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Shiloh Cemetery
Date: 1/7/01
20c. Location - City or Town, State: High View, WV

21. Signature of Funeral Service Licensee: Karen L. Woodell
22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine St. Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septicemia
Due to (or as a consequence of):
b. Thromboembolism
Due to (or as a consequence of):
c. Atherosclerotic Vascular Disease
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Congestive Heart Failure

Chronic Lung Disease

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neil A. Meade MD
29c. License number: D19220
29d. Date signed (Month, Day, Year): January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neil A. Meade 9811 Mallard Dr. Laurel, MD 20708

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: Jennie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00723

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna H. Davis

2. Date of Death Month Day Year: January 9, 2001

3. Time of Death: 7:10 PM

4a. Facility Name *(If not institution, give street and number)*: 4011 Jeffry Street

4b. City, Town, or Location of Death: Wheaton

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 158-26-8319

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 15, 1905

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: NJ

10b. County: Salem

10c. City, Town or Location: Carney's Point

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 30 Maplewood Avenue

10f. Zip Code: 08069

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: George Holston

18. Mother's Name *(First, Middle, Maiden Surname)*: Cidney Harkins

19a. Informant's Name/Relationship *(Type, Print)*: Ronald A. Davis / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4011 Jeffry Street, Wheaton, Maryland 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Newington Cemetery

Date: 01/15/01

20c. Location - City or Town, State: Newington, New Hampshire

21. Signature of Funeral Service Licensee: Richard Hinnen

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Ischemic Cardiomyopathy with left ventricular failure — 1 mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Multisystem organ failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Son's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P Henjum MD

29c. License number: D35045

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip Henjum, M.D. 3416 Olandwood Court, #204, Olney, Maryland 20832

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00724

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marion W. Davidson

2. Date of Death Month Day Year: January 9, 2001

3. Time of Death: 7:45 PM

4a. Facility Name *(If not institution, give street and number)*: Manor Care Nursing Home

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 225-34-2038

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 27, 1932

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13800 Castle Blvd., Apt. 202

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1952-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Marion W. Davidson, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Hattie Gary Crawford

19a. Informant's Name/Relationship *(Type, Print)*: Ethel Davidson / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13800 Castle Blvd., #202, Silver Spring, MD 20904

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: 01/11/01

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 20 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D31563

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles Benner, M.D. 11251 Lockwood Drive, Silver Spring, Maryland 20901

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00725

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Florence M. Deale

2. Date of Death Month / Day / Year: Jan. 2, 2001

3. Time of Death: 9:10 PM

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Rehabilitation & Nursing Center

4b. City, Town, or Location of Death: Burtonsville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 277-12-6991

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 13, 1917

9. Birthplace *(State or Foreign Country)*: Cleveland, Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8504 Springvale Road

10f. Zip Code: 20910

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John Olmstead

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Gibson

19a. Interment's Name/Relationship *(Type, Print)*: Bridget D. Hartman - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7214 Ridgewood Ave., Chevy Chase, Md. 20015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cem.

Date: Jan. 6,01

20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: James E. Dev[illegible]

22. Name and Address of Facility: DeVol Funeral Home 2222 Wisc. Ave., N.W., Wash. D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Merlyn Vemury

29c. License number: D35791

29d. Date signed *(Month, Day, Year)*: Jan 4, 2001

30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: Merlyn K. Vemury, M.D. 9801 Georgia Ave., Silver Spring, Md. 20902

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

GF

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00726

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY MARGARET DRYDEN

2. Date of Death: Month 1 Day 2 Year 2001

3. Time of Death: 12:55 AM

4a. Facility Name (If not institution, give street and number): Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 218-24-2638

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8/4/1930

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Newark

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6369 Worcester Highway

10f. Zip Code: 21841

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Payroll Clerk

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): John Paul Menszak, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Margaret Mary Schwartz

19a. Informant's Name/Reletionship (Type, Print): James Dryden, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6369 Worcester Hwy. Newark, MD 21841

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Garden of Memory | Date: 1/5/01

20c. Location - City or Town, State: Newark, MD

21. Signature of Funeral Service Licensee: Harry Henderson 11003H

22. Name and Address of Facility: Burbage Funeral Home 208 W. Federal St. Snow Hill, MD 21863

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) and menner stated.

29b. Signature end title of certifier: Craig Rogers

29c. License number: Q7955

29d. Dete signed (Month, Dey, Year): 01-02-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Craig Rogers 4040 Eastern Ave. Baltimore, MD 21224

State Registrar

31. Dete filed (Month, Day, Year): JAN 03 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00727

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Vivian Emmons

2. Date of Death: Month January Day 3, Year 2001

3. Time of Death: 9:50 pm

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 577-09-4060

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 3, 1913

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 20600 Neerwinder Street

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Editor

16b. Kind of Business/Industry: American University

17. Father's Name (First, Middle, Last): Clem L. Pigg

18. Mother's Name (First, Middle, Maiden Surname): Rebecca Mebbane

19a. Interment's Name/Relationship (Type, Print): Patricia E. Maslin/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20600 Hazelnut Court, Germantown, Maryland 20874

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: Jan 6 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M. W E. Hagen M00846

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia — 10 d

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 48184

29d. Date signed (Month, Day, Year): Jan. 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elhamy Eskander MD 501 W 7th Street Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2001

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00728

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucy Brooks Ellis
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 4:08 PM
4a. Facility Name (If not institution, give street and number): 1929 East West Highway #204
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 161-28-1232
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 4, 1934
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1929 East West Highway #204
10f. Zip Code: 20910
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. African Specify American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Banquet Waitress
16b. Kind of Business/Industry: Hotel

17. Father's Name (First, Middle, Last): Coley West
18. Mother's Name (First, Middle, Maiden Surname): Mary Ella Brooks

19a. Informant's Name/Relationship (Type, Print): Rohan A. Ellis Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 8653, Silver Spring, MD 20907

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 1/13/01
20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: ▶ Andre Thompson
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic cardiovascular disease — years
Due to (or as a consequence of):
b. Hypertension — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00729

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James W. Eichelberger
2. Date of Death (Month, Day, Year): JANUARY 1 2001
3. Time of Death: 9:00 PM
4a. Facility Name *(If not institution, give street and number)*: Prince Georges Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 343-20-3709
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 29, 1925
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: N/A
10b. County: N/A
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 415 Emerson Street N.W.
10f. Zip Code: 20011
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African-American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Hemotologist
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: James W. Eichelberger
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Herndon

19a. Informant's Name/Relationship *(Type, Print)*: Valerie H. Eichelberger, daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 415 Emerson St. N.W., Washington, D.C. 20011

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rock Creek Cemetery
Date: 1/9/01
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RESPIRATORY FAILURE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D21852
29d. Date signed *(Month, Day, Year)*: JANUARY 4 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A DEVORE MD 4203 QUEENSBURY Rd HYATTSVILLE MD 20781

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6F

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00730

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harold F. Edwards

2. Date of Death (Month, Day, Year): January 5, 2001

3. Time of Death: 2303

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-62-8060

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: January 7,1912

9. Birthplace *(State or Foreign Country)*: Jamaica

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 20509 Neerwinder Street

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: International Labor Relations

16b. Kind of Business/Industry: British Civil Service

17. Father's Name *(First, Middle, Last)*: George Edwards

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Quinn

19a. Informant's Name/Relationship *(Type, Print)*: Candace M. Edwards/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20509 Neerwinder Street, Germantown, Maryland 20874

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: January 10,2001

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Mitt J. Hogan M00846

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis — Hours

Due to (or as a consequence of):

c. Influenza — Hours

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 27330

29d. Date signed *(Month, Day, Year)*: January 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank Listello, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00731

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John E. Edmundson
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 2:34 PM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-18-7376
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct 10, 1916
9. Birthplace *(State or Foreign Country)*: North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 404 Granville Dr
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Automobile Service Manager
16b. Kind of Business/Industry: Flood Pontiac

17. Father's Name *(First, Middle, Last)*: Thomas E. Edmundson
18. Mother's Name *(First, Middle, Maiden Surname)*: Julia O. Gurley

19a. Informant's Name/Relationship *(Type, Print)*: Janette L. Edmundson/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 404 Granville Dr, Silver Spring, MD 20901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park
Date: Jan 8/01
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: ▶ Alan J. Darnell
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

GF

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death): a. Cholangio Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Cholestatic Hepatitis

Due to (or as a consequence of):

c. Hepatic Encephalopathy

Due to (or as a consaquenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ G B Patrick MD
29c. License number: D17729
29d. Date signed *(Month, Day, Year)*: January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George Patrick, III, MD 9221 Colesville Rd, Silver Spring, MD 20910

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 0 8 2001
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00732

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard Edward Egerter

2. Date of Death Month Day Year: January 2, 2001

3. Time of Death: 8:00 am

4a. Facility Name *(If not institution, give street and number)*: 1610 Crestline Road

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 150-14-6748

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 27, 1928

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1610 Crestline Road

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Contract Negotiator

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Harvey Egerter

18. Mother's Name *(First, Middle, Maiden Surname)*: Loretta Fisher

19a. Informant's Name/Relationship *(Type, Print)*: Betty L. Egerter (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1610 Crestline Road Silver Spring, Maryland 20904

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: Jan. 3 2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: John E. Parker

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardio pulmonary Arrest

Due to (or as a consequence of): Mitral Stenosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard S. Goldstein MD

29c. License number: D 20388

29d. Date signed *(Month, Day, Year)*: Jan. 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard S. Goldstein, M.D. 4701 Randolph Road #105 Rockville, Maryland 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 04 2001

32. Registrar's Signature: Geneva B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00733

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Virginia Lee Engerman

2. Dete of Deeth — Month: January Dey: 1, Yeer: 2001

3. Time of Deeth: 0756

4e. Facility Name *(If not institution, giva street and number)*: The Memorial Hospital

4b. City, Town, or Location of Deeth: Easton

4c. County of Deeth: Talbot

Funeral Director

5. Social Security Numbar: 220-09-1309

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: September 12, 1910

9. Birthplaca *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Denton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 2 Engerman Avenue

10f. Zip Code: 21629

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Raca - American Indien, Bleck, White, etc.: Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11 HS Grad; College (1-4or 5+): 4

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Fathar's Nema *(First, Middle, Last)*: John Baynard Schuyler

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Jane Price

19a. Informant's Name/Reletionship *(Type, Print)*: Merry Lee Beaven Daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9373 Kingston Landing Road, Easton, Maryland 21601

20e. Melhod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Junior Order Cemetery

Date: 1/4/01

20c. Location - City or Town, State: Preston, Maryland

21. Signature of Funeral Service Licensee: Randolph C. Moore

22. Neme and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Intarval Between Onsat and Death

Immediate Ceuse (Final disaase or condition resulting in death): e. Acute Cardiac Failure — 8 hours

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediete causa. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last:

b. Hypertensive Cardiovascular Disease — Chronic

Due to (or es e consequenca of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Previous Stroke

23b. Did tobecco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availabla prior to completion of ceuse of deeth? 1☐ Yas 2☐ No

25. Wes casa referred to medical examinar? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Invastigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: Christian E. Jensen, M.D.

29c. License number: D14664

29d. Date signed *(Month, Day, Yeer)*: 01/01/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Christian E. Jensen, M.D., PO Box 690, Denton, Maryland 21629

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JAN 4 2001

32. Registrer's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours afteteath with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Ima 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Fneral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00734

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Salvatore J. Fusco
2. Date of Death Month Day Year: January 5, 2001
3. Time of Death: 12:05 P.M.
4a. Facility Name *(If not institution, give street and number)*: Manor Care Nursing Home
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-26-7107
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 22, 1926
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13200 Clifton Road
10f. Zip Code: 20904
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW-II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Educefion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 10; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: MVA
16b. Kind of Business/Industry: DC Government

17. Father's Name *(First, Middle, Last)*: Salvatore Fusco
18. Mother's Name *(First, Middle, Maiden Surneme)*: Camilla DiNenna

19a. Informant's Neme/Relationship *(Type, Print)*: Patricia Fusco - Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13200 Clifton Road, Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemefery, crematory or other place)*: Fort Lincoln
Date: 1/10/01
20c. Location - City or Town, State: Brentwood, maryland

21. Signature of Funeral Service Licensee: David J. Mitchell
22. Neme end Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. Renal Cell Carcinoma with metastatic spread — 3 months

Due to (or as a consequence ot):

Sequantially list conditions, if sny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events rasulting in death) Last
b.
Due to (or es e consequence ot):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing fo death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streef, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piace, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, In my opinion, death occurred at the time, dete and piece, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: John Margolis MD
29c. License number: D25430
29d. Date signed *(Month, Day, Year)*: 1/9/2001

30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print): John Margolis, MD 13952 Baltimore Ave. Laurel, MD 20707

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 10 2001
32. Registrar's Signetura: Lauren B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00735

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William F. Fyock
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 4:40 AM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220-50-9229
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 27, 1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1609 Coral Sea Drive
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist
16b. Kind of Business/Industry: Medical Clinic

17. Father's Name (First, Middle, Last): William L. Fyock
18. Mother's Name (First, Middle, Maiden Surname): Rose Rest

19a. Informent's Name/Relationship (Type, Print): Rose M. Fyock/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1609 Coral Sea Drive, Rockville, Maryland 20851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park
Date: January 8, 2001
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: M.M.S. Hogue M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Intervel Between Onset end Death
Immediate Cause (Finel disease or condition resulting in death)	a. End Stage Liver Disease	1 Day
Due to (or as a consequence of):	b. Hepatitis C History	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	c. Alcholism	
Due to (or es e consequence of):	d. Coagulopathy	1 Day

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Cirrhosis of Liver

Acute Respiratory Failure 1 Day

Hepatic Encepholapathy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vinu Ganti
29c. License number: D41162
29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Vinu Ganti, M.D., 19529 Doctor's Drive, Germantown, Maryland 20874

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrer's Signature: Steven B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00736

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Yetta Furman.

2. Date of Death: Month JAN. Day 6 Year 2001

3. Time of Death: 5:30 AM

4a. Facility Name (If not institution, give street and number): 1400 CRESTRIDGE DR.

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 229-10-9411

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 7, 1917

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1400 CRESTRIDGE DR.

10f. Zip Code: SILVER SPRING

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKKEEPER

16b. Kind of Business/Industry: BUILDER

17. Father's Name (First, Middle, Last): JOSEPH MILLER

18. Mother's Name (First, Middle, Maiden Surname): FANNIE LAIBSTEIN

19a. Informant's Name/Relationship (Type, Print): NORMAN FURMAN/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1400 CRESTRIDGE DR. SILVER SPRING, MD 20910

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEMORIAL GARDEN 2001 Date: 01/08

20c. Location - City or Town, State: FALLS CHURCH, VA

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sudden Heart Failure — Acute

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Recent Small Bowel Ileus, Hiatal Hernia, Schizophrenia, Dementia, Atherosclerosis Hypothyroidism, Diverticulosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD Covering Physician

29c. License number: D31001

29d. Date signed (Month, Day, Year): 1/6/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart J. Turkewitz, M.D. 7500 Greenway Cntr. Dr. #430 Greenbelt, MD. 20770

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00737

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Christina Veronica Franklin
2. Date of Death Month Day Year: January 7, 2001
3. Time of Death: 1:45 am
4a. Facility Name *(If not institution, give street and number)*: Potomac Valley Wellness & Nursing Center
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 199-16-6901
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 15, 1913
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14304 Morton Hall Road
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Walter Piffer
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Schmiederer

19a. Informant's Name/Relationship *(Type, Print)*: Christina F. Zimmerman/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14304 Morton Hall Road, Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: Jan 10 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Walter Goozh, MD
29c. License number: D 01120
29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Walter Goozh, MD 1299 Lamberton Drive, Silver Spring, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00738

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Barbara Ann Faulkner
2. Date of Death (Month, Day, Year): January 2, 2001
3. Time of Death: 1:10 PM
4a. Facility Name *(If not institution, give street and number)*: 4925 Battery Lane
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 381-34-8143
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 27, 1906
9. Birthplace *(State or Foreign Country)*: Missouri

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4925 Battery Lane
10f. Zip Code: 20814
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Emmett M. Fite
18. Mother's Name *(First, Middle, Maiden Surname)*: Bess Stafford

19a. Interment's Name/Relationship *(Type, Print)*: Barbara Carol Peck / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14910 Brownstone Drive, Burtonsville, MD 20866

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory — Date: 01/09/01
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D0952-MD
29d. Date signed *(Month, Day, Year)*: January 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Schoenfeld, M.D. 5530 Wisconsin Ave., Chevy Chase, Maryland 20815

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

VOID

CERTIFICATE #

QL-00739

SEE

CERTIFICATE #

QQ-Y3643

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00740

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose Mary Cecilia Faour

2. Date of Death (Month, Day, Year): January 6, 2001

3. Time of Death: 6:00 am

4a. Facility Name (If not institution, give street and number): 8502 16th Street Apt 110

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-44-9318

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 24, 1934

9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8502 16th Street Apt 110

10f. Zip Code: 20910

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Administrator

16b. Kind of Business/Industry: Travel

17. Father's Name (First, Middle, Last): Frank DeCarlo

18. Mother's Name (First, Middle, Maiden Surname): Mary Vinqueso

19a. Informant's Name/Relationship (Type, Print): Jimmie Lee Faour / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8502 16th Street Apt 110, Silver Spring, MD 20910

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: Jan 10 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 4 1/2months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 43083

29d. Date signed (Month, Day, Year): January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George A. Sotos, MD 9707 Medical Center Drive, Suite 300, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00741

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roland Henry Flint
2. Date of Death Month Day Year: Jan. 2, 2001
3. Time of Death: 8:35 a.m.
4e. Facility Name (If not institution, give street and number): 9819 Haverhill Drive
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 501-28-7061
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 27, 1934
9. Birthplace (State or Foreign Country): Park River, ND.

Usual Residence of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9819 Haverhill Drive
10f. Zip Code: 20895
10g. Citizen of What Country?: United States

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1954-56
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor
16b. Kind of Business/Industry: University Studies

17. Father's Name (First, Middle, Last): William Henry Flint
18. Mothar's Name (First, Middle, Maiden Surneme): Orva Hastings

19a. Inlormant's Name/Ralationship (Type, Print): Helen Rosalind Cowie/ Wife
19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 9819 Haverhill Dr., Kensington, Md. 20895

20e. Method ol Disposition: 1 [ ] Burial 2 [X] Cremelion 3 [ ] Removel Irom Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place ol Disposition (Neme of cemetery, cremetory or other place): Chesapeake Crematory Inc
Dete: 1/6/01
20c. Location - City or Town, State: Beltsville, Md.

21. Signeture of Funeral Service Licensee: Dennis A Shandy
22. Name end Address ol Facility: Rapp, Funeral and Cremation Services, Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, Md. 20910

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions that caused the death. Do not enter tha mode of dying, such as cardiec or respiretory errest, shock, or heart lellure. List only one cause on eech line. — Approximata Intarval Between Onset and Death

Immedieta Causa (Finel disease or condition resulting in death): e. Cardiac Arrest
Due to (or as a consequence ol):
Sequantiellly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Pancreatic Cancer
Due to (or es a consequence ol):
c.
Due to (or es a consequence ol):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to complation of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa rafarred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner ol Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could nol be detarmined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Plece ol Injury - At homa, larm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best ol my knowledge, death occurred at tha time, data and piece, and dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et tha time, dete end place, and due to the ceuse(s) and mennar steted.

29b. Signature and title ol certiliar: Jeanne D. Taylor MD
29c. License number: D29283
29d. Data signed (Month, Dey, Year): 1-3-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 10810 Connecticut Ave Kensington MD 20895

State Registrar

31. Date filed (Month, Day, Year): JAN 05 2001
32. Registrer's Signeture: Irene G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

50+1

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00742

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Juanita M. Guild

2. Date of Death: Month January Day 6, Year 2001

3. Time of Death: 6:30A.

4a. Facility Name (If not institution, give street and number): Magnolia Gardens Nursing Home

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-20-4049

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March26,1904

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Adelphi

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 2717 Hughes Raod

10f. Zip Code: 20783

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator

16b. Kind of Business/Industry: U.S. Government

17. Father's Neme (First, Middle, Last): Gilbert McDonald

18. Mother's Name (First, Middle, Maiden Sumame): Lottie Hutchings

19a. Informent's Neme/Reletionship (Type, Print): Chester H. Guild - son

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10a - 10g

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Fort Lincoln Cemetery Dete: 1/10/2001

20c. Location - City or Town, Stete: Brentwood, Maryland

21. Signeture of Funerel Service Licensee: Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill RD. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line. Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): a. Cerebrovascular Disease

Due to (or es e consequence of):

Sequentielly iist conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Phyaician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and menner steted.

29b. Signeture end titie of certifier: George C. Hagar, Jr.

29c. License number: 039550

29d. Date signed (Month, Day, Year): 1-6-01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): George C. Hagar, Jr. M.D. 4850 Forbes Blvd Lanham, Md 20706

State Registrar

31. Dete filed (Month, Dey, Year): JAN 0 9 2001

32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #29d, 1/9/2001, BMW, Montg.Co.

Certificate of Death

Reg. No. 2001 00743

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STEPHEN LEWIN GROSSMAN
2. Data of Deeth — Month: JAN Day: 7 Year: 2001
3. Time of Death: 6:25 AM
4a. Facility Neme (If not institution, give street end number): NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Daeth: BETHESDA
4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 137-28-4691
6. Sax: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 65 Yrs.
If Under 1 Yaer — Months: Deys:
If Under 24 Hrs. — Hours: Min.:
8. Deta of Birth (Month, Day, Year): Dec.2,1935
9. Birthplaca (State or Foreign Country): New Jersey

Usual Rasidance of Decedant

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Insida City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 1617 Arbor View Road
10f. Zip Coda: 20902
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Nevar Marriad 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yas, Giva Yeer or Detes: 1972-1995
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decadant's Education (Specify only highest grade completed) — Elemantary/Secondary (0-12): 12 — College (1-4or 5+): 5+
16a. Dacedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Law Judge
16b. Kind of Businass/Industry: Law

17. Fether's Nama (First, Middle, Last): Harold Grossman
18. Mothar's Name (First, Middle, Maiden Surname): Eve Rae Levine

19a. Informent's Name/Ralationship (Type, Print): Ann M. Grossman - wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): same as #10a - 10g

20a. Mathod of Disposition: 1 [X] Buriat 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Arlington National Cemetery
Data: 1/17/01
20c. Location - City or Town, Stata: Arlington, Virginia

21. Signature of Funaral Service Licensee: By Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Deeth

Immadiata Causa (Finat diseese or condition rasulting in daath)
a. METASTATIC LUNG CANCER
Due to (or as a consequence of):
Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Ceuse (Diseese or injury thet initiated events rasulting in daath) Last
b.
Due to (or as a consaquanca of):
c.
Due to (or as a consaquanca of):
d.

Part II. Other significant conditions contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings availeble prior to complation of cause of daath? 1 [ ] Yes 2 [ ] No

25. Was casa rafarred to medical exeminer? 1 [ ] Yas 2 [X] No
26. Piece of Death (Check only one): Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidanca 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Panding Invastigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1 [X] **Cartifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and mannar stated.
29b. Signature and title of certifiar: MD
29c. Licansa number: RES-000
29d. Data signed (Month, Day, Year): January 8, 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): G.S.NAYAK, LT, MC, USN
NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: Donna B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00744

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALBERT H. GREENE
2. Date of Death Month Day Year: JANUARY 6, 2001
3. Time of Death: 3:20 AM
4a. Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-38-6103
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 89 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 26, 1911
9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: POTOMAC
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9121 CRANFORD DRIVE
10f. Zip Code: 20854
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ATTORNEY
16b. Kind of Business/Industry: LEGAL

17. Father's Name *(First, Middle, Last)*: HYMAN GREENSTEIN
18. Mother's Name *(First, Middle, Maiden Surname)*: MINNA FERBER

19a. Informant's Name/Relationship *(Type, Print)*: DAVID S. GREENE/SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9121 CRANFORD DRIVE, POTOMAC, MARYLAND 20854

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: NEW MONTEFIORE CEMETERY
Date: JAN 09, 2001
20c. Location - City or Town, State: FARMINGDALE, NEW YORK

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Stroke — Approximate Interval: 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D24942
29d. Date signed *(Month, Day, Year)*: JAN 06 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00745

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IVY E. GREEN
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 5:45 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-03-2913
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 25, 1914
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9101- 2nd Avenue
10f. Zip Code: 20910
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Dept. of Public Health D.C. Government

17. Father's Name (First, Middle, Last): George B. Green
18. Mother's Name (First, Middle, Maiden Surname): Effie Williams

19a. Interment's Name/Relationship (Type, Print): Malcolm Lawrence (Nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3807 Taylor Street, Chevy Chase, MD 20815

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rock Creek Cemetery
Date: 01/09/01
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: W. Kelly Mung
22. Name and Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 Wisconsin Ave., NW Washington, DC 20016

G.F.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration pneumonitis.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure
Interstitial Pulmonary Fibrosis
Renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D57083
29d. Date signed (Month, Day, Year): 01-06-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TISA O. YUSUF 6712 VILLAGE PARK DR, GREENBELT MD 20770

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

01-0052-031
B.K.S
JARED GORFAIN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00746

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JARED COLE GORFAIN
2. Date of Death (Month, Day, Year): JAN. 3, 2001
3. Time of Death: 1746 PM
4a. Facility Name (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 383-02-6001
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 15 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04-08-1985
9. Birthplace (State or Foreign Country): MI

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: OLNEY
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2906 CLOVERCREST WAY
10f. Zip Code: 20832
10g. Citizen of Whet Country?: USA
11. Meritel Stetus: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10 | College (1-4or 5+)
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): STUDENT
16b. Kind of Business/Industry: HIGH SCHOOL
17. Father's Neme (First, Middle, Last): STEVE H. GORFAIN
18. Mother's Name (First, Middle, Maiden Surneme): LINDA BERYL GELMAN
19a. Informent's Neme/Reletionship (Type, Print): STEVE H. GORFAIN/FATHER
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2906 CLOVERCREST WAY, OLNEY, MARYLAND 20832
20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): JUDEAN MEMORIAL GARDENS | Dete: JAN 8, 2001
20c. Location - City or Town, Stete: OLNEY, MARYLAND
21. Signature of Funeral Service Licensee:
22. Neme and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart teilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death): a. Multiple Injuries

Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequenca of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospitel: 1 ☐ inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☐ Netural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey, Yeer): 01/03/01
28b. Time of Injury: 1709 M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Operator of motorcycle struck fixed object
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify): STREET
28f. Location (Street end Number or Rural Route Number, City or Town, Stete): Old Baltimore Rd/Owens Rd.

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated. 2 ☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) end menner steted.

29b. Signature and title of certifier:
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN. 4, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 09 2001
32. Registrer's Signetura: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00747

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA AILEEN GLASSFORD

2. Date of Death — Month: January Day: 7, Year: 2001

3. Time of Death: 6:35 AM

4e. Facility Name (If not institution, give street and number): Wilson Health Care Center

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 294-14-1241

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 21, 1925

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 301 Russell Avenue

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager

16b. Kind of Business/Industry: Dental

17. Father's Name (First, Middle, Last): Jess Hale

18. Mother's Name (First, Middle, Maiden Surname): Annie Randolph

19a. Informant's Name/Relationship (Type, Print): Joyce Lewkowski/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11513 Evelake Court, Gaithersburg, MD. 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: 1/9/01

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Bronchopneumonia — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lung Cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D33357

29d. Date signed (Month, Day, Year): 1/08/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee Jonathan Musler MD 5530 Wisconsin Ave Chevy Chase MD

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00748

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul F. Gannon
2. Data of Death — Month: January Day: 8 Year: 2001
3. Time of Death: 3:54 p.m.
4a. Facility Name *(If not Institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 021-24-5541
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Oct. 7, 1931
9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Rasidanca of Dacedant

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Derwood
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10a. Street and Number: 17516 Park Mill Drive
10f. Zip Code: 20855
10g. Citizen of What Country?: United States

11. Meritel Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yas, Giva Yeer or Detes: 54-56
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Rece - American Indien, Bleck, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondery (0-12) / Collega (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Linguistic Analyst
16b. Kind of Business/Industry: Federal Government

17. Fathar's Nama *(First, Middla, Last)*: Francis Joseph Gannon
18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Estelle Shea

19a. Informant's Name/Reletionship *(Type, Print)*: Carol A. Gannon/ Spouse
19b. Meiling Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 17516 Park Mill Drive, Derwood, MD 20855

20a. Mathod of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Ramovel from State 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Name of camatary, cramatory or othar placa)*: Gate of Heaven Cemetery — Data: January 13, 2001
20c. Location - City or Town, Stata: Silver Spring, MD

21. Signeture of Funaral Service Licensea: ▶ Tracy A. Stuver
22. Name end Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Entar tha diseesa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only ona ceuse on each lina. — Approximate Intervel Between Onset end Death

Immediata Causa (Final disaasa or condition resulting in death)
a. METASTATIC COLON CARCINOMA — 3 YRS.
Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in daath) Last
b.
Due to (or as a consequanca of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.
ACUTE MYOCARDIAL INFARCTION
SEPSIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yas 2 [ ] No
24b. Ware autopsy findings available prior to complation of causa of daath? 1 [ ] Yes 2 [✓] No

25. Was casa rafarred to medical examinar? 1 [ ] Yas 2 [✓] No
26. Place of Death *(Check only one)*: Hospitel: 1 [✓] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Mannar of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarminad
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street end Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1 [✓] **Certifying Phyeician:** To tha best of my knowledga, death occurred at tha time, data and placa, and dua to tha causa(s) and mannar es stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date and placa, and due to tha cause(s) and manner stated.

29b. Signatura end titla of certifiar: ▶ Victor Priego MD
29c. License number: D23308
29d. Dete signed *(Month, Day, Year)*: JAN. 9, 2001

30. Nama and address of parson who completed cause of daath (Item 23a) (Type, Print): VICTOR M. PRIEGO, MD 6410 ROCKLEDGE DR. SUITE #625 BETHESDA, MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Gannon Paul F. 1-8-01 1554

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00749

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerald L. Howett
2. Date of Death (Month, Day, Year): January 2, 2001
3. Time of Death: 12:18 a.m.
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 119-26-7629
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 27, 1931
9. Birthplace (State or Foreign Country): Unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10604 Muirfield Drive
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor
16b. Kind of Business/Industry: University Studies

17. Father's Name (First, Middle, Last): Abraham Howett
18. Mother's Name (First, Middle, Maiden Surname): Rose(Unknown)

19a. Interment's Name/Relationship (Type, Print): Albert Perlmatter/ Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 43-10 Kissena Blvd., Apt. 6A, Flushing, NY. 11355

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Park Cemetery
Date: Jan. 5, 2001
20c. Location - City or Town, State: Emerson , New Jersey

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name and Address of Facility: Cremation and Funeral Alternatives, Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, Md. 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Intractable Cardiac Arrhythmia

Due to (or as a consequence of):
b. Acute Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Coronary Artery Bypass Surgery

Due to (or as a consequence of):
d. Angioplasty and Coronary Stenting

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Worsening Renal Failure

Poor left Ventricular Function

Hematuria

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
26a. Date of Injury (Month, Day, Year)
26b. Time of Injury
26c. Injury at Work? 1☐ Yes 2☐ No
26d. Describe how injury occurred
26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 53601
29d. Date signed (Month, Day, Year): Jan.3, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Mohsin ; 11119 Rockville Pike, #100, Rockville, Md. 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00750

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Kathryn Hougum
2. Date of Death (Month, Day, Year): January 7, 2001
3. Time of Death: 2:15 AM
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 390-07-0352
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 29, 1917
9. Birthplace (State or Foreign Country): Wisconsin

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: North Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10825 Tuckahoe Way
10f. Zip Code: 20878
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant
16b. Kind of Business/Industry: University of Wisconsin

17. Father's Name (First, Middle, Last): Henry F. Schultz
18. Mother's Name (First, Middle, Maiden Surname): Flora Splinter

19a. Informant's Name/Relationship (Type, Print): Craig Hougum/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10825 Tuckahoe Way, North Potomac, Maryland 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Roselawn Cemetery
Date: 1/13/01
20c. Location - City or Town, State: Madison, Wisconsin

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. corticobasilar ganglionosis — 1/years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 20198
29d. Date signed (Month, Day, Year): January 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Dolinsky 911 Russell Ave. Gaithersburg Md.

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00751

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELNORA FORD HARDEN
2. Date of Death Month / Day / Year: JAN. 6, 2001
3. Time of Death: 3:30 AM
4a. Facility Name *(If not institution, give street and number)*: 12357 SANDY POINT CT.
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 290-12-7493
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 25, 1921
9. Birthplace *(State or Foreign Country)*: OHIO

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12357 SANDY POINT CT.
10f. Zip Code: 20904
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: MACK KELLY FORD
18. Mother's Name *(First, Middle, Maiden Surname)*: VIOLA MINERVA ELLISON

19a. Informant's Name/Relationship *(Type, Print)*: SOYINI JANICE HARDEN/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: SAME AS ITEM #10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHAMBERS CREMATORY
Date: 1/9/01
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers M00091
22. Name and Address of Facility: 5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cholangiocarcinoma — weeks
Due to (or as a consequence of):
b. congestive heart failure — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D50678
29d. Date signed *(Month, Day, Year)*: 1/8/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJEEV BATRA, M.D. 10801 LOCKWOOD DR. #325, SILVER SPRING, MD. 20901

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00752

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elaine Lucy Hayes

2. Date of Death Month: JANUARY Day: 03, Year: 2001

3. Time of Death: 08:28 A.M.

4a. Facility Name *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: CAMP SPRINGS

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 379-16-5510

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth *(Month, Day, Year)*: April 5, 1924

9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: VA

10b. County: Loudoun

10c. City, Town or Location: Leesburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 43187 Parkers Ridge Drive

10f. Zip Code: 20176

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Florist

16b. Kind of Business/Industry: Flower Shop

17. Father's Name *(First, Middle, Last)*: Harold M. Howland

18. Mother's Name *(First, Middle, Maiden Surname)*: Leona Cormier

19a. Informant's Name/Relationship *(Type, Print)*: Vickie M. Goodale - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 43187 Parkers Ridge Drive Leesburg, VA 20176

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Milton Cemetery

Date: 1/6/01

20c. Location - City or Town, State: Milton, WI

21. Signature of Funeral Service Licensee: Dennis G. Pittman

22. Name and Address of Facility: Colonial Funeral Home 201 Edwards Ferry Rd. NE Leesburg VA

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disaasa or condition resulting in death)

a. HYPOXEMIA — 05 MINUTES

Due to (or as a consequence of):

b. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 20 YEARS

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other signifficant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uss contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to compiation of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature] MD

29c. Licansa number: DE 3318

29d. Data signed *(Month, Day, Year)*: JANUARY 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN K. KIM, CAPT, USAF, MC 1050 W. PERIMETER ROAD/89 MDG ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signeture: [signature] B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00753

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Lucas Hays
2. Date of Death (Month, Day, Year): January 8, 2001
3. Time of Death: 3:30 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-18-4594
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 16, 1922
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12812 Lacy Drive
10f. Zip Code: 20904
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk of the Court
16b. Kind of Business/Industry: Montgomery County Gov.
17. Father's Name (First, Middle, Last): James Lucas
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Proehl
19a. Informant's Name/Relationship (Type, Print): Raymond L. Hays, Jr. / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12812 Lacy Drive, Silver Spring, Maryland 20904
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Stonewall Memorial Gard.
Date: 01/12/01
20c. Location - City or Town, State: Manassas, Virginia
21. Signature of Funeral Service Licensee: Andrew J. Hines
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Necrotizing pancreatitis	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Recurring septic shock	
Due to (or as a consequence of):		
	c. Respiratory Failure	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L. Bahadori
29c. License number: D47928
29d. Date signed (Month, Day, Year): January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lila Bahadori, M.D. 10301 Georgia Ave., #304, Silver Spring, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00754

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mabel E. Heckard

2. Date of Death Month Day Year: January 5, 2001

3. Time of Death: 2:10PM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-28-6023

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 27, 1907

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4400 East West Highway #515

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator

16b. Kind of Business/Industry: United States Government

17. Father's Name *(First, Middle, Last)*: John Flemming Shaw

18. Mother's Name *(First, Middle, Maiden Surname)*: Flora May Turner

19a. Informant's Name/Relationship *(Type, Print)*: Dona Jean Arbuco/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4400 East West Highway #515, Bethesda, Maryland 20814

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Montgomery Crematorium, Inc.

Date: January 8, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signeture of Funeral Service Licensee: ▶ [signature] M01126

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

G.F

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Renal Failure

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Ralph Nelson

29c. License number: D01191

29d. Date signed *(Month, Day, Year)*: January 5, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Ralph M. Coan, M.D. 9618 Culver Street, Kensington, Maryland 20895

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001

32. Registrer's Signature: Donna B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Heckard MABel 1-5-01-1410

20

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00755

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clement F. Heddleson
2. Date of Death (Month, Day, Year): January 6, 2001
3. Time of Death: 7:30 AM
4a. Facility Name *(If not institution, give street and number)*: 9619 Carriage Road
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 268-20-3455
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 1,1924
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9619 Carriage Road
10f. Zip Code: 20895
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Yaar or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Business/Industry: Defense

17. Father's Name *(First, Middle, Last)*: Everett C. Heddleson
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Grace Fretts

19a. Informant's Name/Relationship *(Type, Print)*: Mary Ann Heddleson/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9619 Carriage Road, Kensington, Maryland 20895

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.
Date: January 9,2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Michael B. Hogan M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter tha *mode* of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sudden Cardiac Death	2 Minutes
Due to (or as a consequence of):		
b.	Congestive Heart Failure	2 Years
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of):		
c.	Valvular Heart Disease	30 Years
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicet axaminar? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Homa 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allan A. Nimitz MD
29c. License number: D07147
29d. Data signed *(Month, Day, Year)*: January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allan A. Nimitz, M.D., 5401 Western Avenue, N.W., Washington, D.C. 20015-2998

State Registrar

31. Data filed *(Month, Day, Yeat)*: JAN 10 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00756

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gurvis Henry
2. Date of Death (Month, Day, Year): Jan. 2, 2001
3. Time of Death: 7:15 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 385-76-8362
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun. 5, 1931
9. Birthplace (State or Foreign Country): Jamaica

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2404 Lewisdale Drive
10f. Zip Code: 20783
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plasterer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Angell J. Henry/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2404 Lewisdale Drive, Adelphi, MD 20783

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: Jan. 8, 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: ▶ Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Asystole

Due to (or as e consequence of):
b. Massive Anterior Lateral Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as e consequence of):
c. Renal failure

Due to (or es a consequence of):
d. Diabetes mellitus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Kathleen McShane
29c. License number: D16073
29d. Date signed (Month, Day, Year): 1/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen McShane 1500 Forest Glen Rd., Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signature: ▶ Steven G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0016-031
B.K.S

Joan Herman

UNKNOWN 01-003

AMENDED ITEMS# 23a,27,28a-f per M.E. G792 020901 SS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00757

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joan M. Herman

2. Date of Death Month Day Year: JAN. 1, 2001

3. Time of Death: 10:15 AM

4a. Facility Name *(If not institution, give street and number)*: 1117 CRESTHAVEN DRIVE

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-46-8795

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 15, 1937

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1117 Cresthaven Drive

10f. Zip Code: 20903

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Health Care

16b. Kind of Business/Industry: Elderly/Handicapped Services

17. Father's Name *(First, Middle, Last)*: Raphael Angelo Trapani

18. Mother's Name *(First, Middle, Maiden Surname)*: Emilia Mongelli

19a. Informant's Name/Relationship *(Type, Print)*: Michael Herman/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18610 Walker's Choice Road #2, Montgomery Village, MD 20879

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: Jan. 6, 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Eric J Scerbo

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SMOKE INHALATION

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* AT SCENE

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: found: 1-1-01

28b. Time of Injury: found: 10:15 A

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: subject involved in a house fire/explosion

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: residence

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 1117 Cresthaven Dr. Silver Spring, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Chute MD

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: JAN. 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J Chute 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0015-031
B.K.S.
UNKNOWN 01-001
Stanley Herman

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEMS# 23a,27,& 28a-f G792 020901 SS per M.E.

Reg. No. 2001 00758

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Stanley Alan Herman
2. Dete of Death (Month, Dey, Yeer): JAN. 1, 2001
3. Time of Death: 10:10 AM
4a. Facility Neme (If not institution, give street end number): 1117 CRESTHAVEN DRIVE
4b. City, Town, or Location of Deeth: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Sociat Security Number: 214-34-9041
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 62 Yrs. (If Under 1 Yeer: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Dete of Birth (Month, Day, Year): Feb. 4, 1938
9. Birthplace (State or Foreign Country): DC

Usuet Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1117 Cresthaven Drive
10f. Zip Code: 20903
10g. Citizen of What Country?: USA

11. Meritat Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: Unknown
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12); Collega (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronics Technician
16b. Kind of Business/Industry: Repair

17. Father's Neme (First, Middle, Last): David Herman
18. Mother's Neme (First, Middle, Maiden Surname): Goldie Horowitz

19a. Informent's Neme/Reletionship (Type, Print): Michael Herman / Son
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 18610 Walker's Choice Rd, #2, Montgomery Village, MD 20879

20a. Method of Disposition: 1☒ Buriat 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Gate of Heaven Cemetery
Dete: Jan. 6, 2001
20c. Location - City or Town, Stata: Silver Spring, MD

21. Signeture of Funeral Service Licensee: ▶ Eric S. Scerbo
22. Neme end Address of Feciliity: Francis J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feiture. List only one ceusa on eech line. (Approximete Intervet Between Onset end Death)

Immediate Ceuse (Finel diseese or condition resulting in deeth):
a. SMOKE INHALATION
Due to (or as e consequenca of):
Sequentiatly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
b.
Dua to (or as s consequenca of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Wara autopsy findings aveilable prior to compiation of cause of deeth? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Deeth (Check only ona): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Rasidence 6☒ Other (Specify) AT SCENE

27. Mannar of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be datarmined
28a. Dete of Injury (Month, Day Year): found: 1-1-01
28b. Time of Injury: found: 10:15 A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject involved in house fire/ explosion
28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify): residence
28f. Location (Street end Number or Rural Route Number, City or Town, Stata): 1117 Cresthaven Dr. SilverSpring, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To tha best of my knowledga, daeth occurred at the time, dete end plece, and dua to tha cause(s) and mannar as stated. 2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, daeth occurred et tha time, dete end place, and due to tha cause(s) and menner steted.

29b. Signeture end titte of certifier: ▶ Dennis J. Chute MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN. 2, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 0 8 2001
32. Registrer's Signeture: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00759

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGUERITE DYSON HOWES HIGGINS
2. Date of Death (Month, Day, Year): JANUARY 7, 2001
3. Time of Death: 4:55 AM
4a. Facility Name (If not institution, give street and number): BROOKE GROVE NURSING HOME
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-24-5270
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 26, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 1709 Hopefield Road
10f. Zip Code: 20905
10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John G. Howes
18. Mother's Name (First, Middle, Maiden Surname): Mamie Wachter

19a. Informant's Name/Relationship (Type, Print): George C. Higgins, Jr. / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1709 Hopefield Road, Silver Spring, Md. 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Goshen Cemetery
Date: 1/10/01
20c. Location - City or Town, State: Goshen, Maryland

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ADVANCED SENILE DEMENTIA — YEARS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T E Howe MD
29c. License number: D33700
29d. Date signed (Month, Day, Year): JANUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED E. HOWE 154 N. ARTIZAN ST. WILLIAMSPORT, MD 21795

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00760

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTHA E. HILL
2. Date of Death (Month, Day, Year): JAN. 4, 2001
3. Time of Death: 10:40 AM
4a. Facility Name (If not institution, give street and number): 13813 BONSAL LA.
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-50-5704
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 4, 1911
9. Birthplace (State or Foreign Country): MINNESOTA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13813 BONSAL LA.
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: FED. GOV'T.

17. Father's Name (First, Middle, Last): JERONE TILFORD LOVE
18. Mother's Name (First, Middle, Maiden Surname): JENNIFER SMITH

19a. Informant's Name/Reletionship (Type, Print): PARKER T. HILL/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): CHAMBERS CREMATORY
Date: 1/6/01
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MO0091
22. Name and Address of Facility: 5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in death)
a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):
b. CORONARY HEART FAILURE
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
d. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Ira Tauber MD
29c. License number: D18813
29d. Date signed (Month, Day, Year): JAN. 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRA TAUBER, M.D. 10301 GEORGIA AVE., SUITE 304, SILVER SPRING, MD. 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00761

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Virginia Hopkins
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 12:30PM
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-09-8153
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 28, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 110 Charles Street
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Sales Clerk
16b. Kind of Business/Industry: Department Store

17. Father's Name *(First, Middle, Last)*: Not Available
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Fannie Bennett

19a. Intorment's Neme/Raletionship *(Type, Print)*: Pauline V. Kinder/Cousin
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 339 Seth Place, Rockville, Maryland 20850

20a. Mathod ot Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa ot Disposition *(Name of cemetery, cremetory or other place)*: George Washington Cemetery
Data: Jan 9 2001
20c. Location - City or Town, Steta: Adelphi, Maryland

21. Signeture of Funerel Service Licensee: David E. Perry M00803
22. Neme end Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the moda of dying, such es cardiec or respiretory errast, shock, or heert feilure. List only one ceuse on aech line.

		Approximeta Interval Between Onset and Deeth
Immediate Cause (Finel disease or condition resulting in deeth) a.	Acute Renal Failure	5 Days
Dua to (or es a consequence of):		
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in deeth) Last — b.	MRSA Bacteremia/Septicemia	8 Days
Due to (or es e consequence of):		
c.	Endocarditis	2 Weeks
Due to (or es a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease; Congestive Heart Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa retarrad to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be datarmined
28e. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, tarm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at tha time, data and place, end due to tha cause(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of examinetion and/or investigetion, in my opinion, deeth occurred at tha time, data and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D56652
29d. Data signed *(Month, Day, Year)*: January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Matthew Poffenroth, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00762

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MEREDITH HAWES
2. Date of Death: Month JANUARY Day 1, Year 2001
3. Time of Death: 12:35 AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-16-1846
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 17 1922
9. Birthplace (State or Foreign Country): Brunswick MD

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Brunswick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 319 W. Potomac Street
10f. Zip Code: 21716
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Car Inspector
16b. Kind of Business/Industry: B&O Railroad Brunswick, MD

17. Father's Name (First, Middle, Last): Harry Wilson Hawes
18. Mother's Name (First, Middle, Maiden Surname): Mamie Etta Price

19a. Informant's Name/Relationship (Type, Print): Janet Lee Hall, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3304 Carlisle Drive, Knoxville, MD 21758

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Park Heights Cemetery
Date: 1/4/01
20c. Location - City or Town, State: Brunswick, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams
Barbara A. Williams, Owner
22. Name and Address of Facility: John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD 21716

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Pulmonary edema — hours

Due to (or as a consequence of):
b. Coronary artery disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Chronic Obstructive Pulmonary disease — years

Due to (or as a consequence of):
d. Upper gastrointestinal bleed — days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Significant Anemia, diabetes mellatus, Hypothyroidism
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD, MPH
29c. License number: D47169
29d. Date signed (Month, Day, Year): 1/1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chan-hing HO 610 9th Ave., Brunswick, MD 21716

State Registrar

31. Date filed (Month, Day, Year): JAN 03 2001
32. Registrar's Signature: Bonnie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00763

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Franklin Hufstedler
2. Data of Death (Month, Day, Year): January 1, 2001
3. Time of Death: 1:30 PM
4a. Facility Name (If not institution, give street and number): Asbury- Solomons Health Care Center
4b. City, Town, or Location of Death: Solomons
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 456 10 3061
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Dec 6, 1920
9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Solomons
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 11450 Asbury Circle #132
10f. Zip Code: 20688
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 43-73
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Naval officer
16b. Kind of Business/Industry: military US Government
17. Father's Name (First, Middle, Last): Edward F. Hufstedler
18. Mother's Name (First, Middle, Maiden Surname): Maura Hudspeth
19a. Informant's Name/Relationship (Type, Print): Georgia Ann Hufstedler - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11450 Asbury Circle #132 Solomons Maryland 20688
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Metropolitan Funeral Service
Date: Jan 2, 2001
20c. Location - City or Town, State: Alexandria Virginia
21. Signature of Funeral Service Licensee: B Rausch
22. Name and Address of Facility: Rausch Funeral HOme PA 4405 Broomes Is. Rd. Port Republic MD 20676

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: David J Tardio MD
29c. License number: 047610
29d. Date signed (Month, Day, Year): January 2, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J. Tardio MD Prince Frederick MD 20676

State Registrar

31. Date filed (Month, Day, Year): JAN 1 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended # 2, MHS, 1/5/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00764

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hazel Adeline Hitchins

2. Date of Death Month Day Year: January 03, ~~2000~~ 2001

3. Time of Death: 08:00 AM

4a. Facility Name *(If not institution, give street and number)*: 13521 Old Legislative Road, S.W.

4b. City, Town, or Location of Death: Woodland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 212-01-9801

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 25-Jun-19

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Frostburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13521 Old Legislative Road, S.W.

10f. Zip Code: 21532-

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: seamstress

16b. Kind of Business/Industry: clothing manufacturing

17. Father's Name *(First, Middle, Last)*: Walter Patterson

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Miller

19a. Informant's Name/Relationship *(Type, Print)*: Harry Hitchens son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 155 Grantsville Maryland 21536-

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Frostburg Memorial Park

Date: 05-Jan-01

20c. Location - City or Town, State: Frostburg, Maryland

21. Signature of Funeral Service Licensee: John R. Durst

22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — About 4 months

Due to (or as a consequence of):

b. ISCHEMIC DILATED CARDIOMYOPATHY — About 5 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. CORONARY ARTERY DISEASE — About 7 years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

AORTIC VALVE STENOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D26907

29d. Data signed *(Month, Day, Year)*: JANUARY 04, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, Maryland 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 04 2001

32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10
MHS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00765

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Yang Soon Im

2. Date of Death (Month, Day, Year): January 7, 2001

3. Time of Death: 11:40 PM

4a. Facility Name (If not institution, give street and number): 14913 Wellwood Road

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-15-3312

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 16, 1919

9. Birthplace (State or Foreign Country): Korea

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14913 Wellwood Road

10f. Zip Code: 20904

10g. Citizen of What Country? Korea

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Chul Soon Im / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14913 Wellwood Road, Silver Spring, Maryland 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 01/10/01

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Bladder Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Renal Failure

Due to (or as a consequence of):

c. Severe Anemia

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D0021033

29d. Date signed (Month, Day, Year): January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Byoung Kie Lee, M.D. 13000 Georgia Avenue, Silver Spring, Maryland 20906

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001 00766

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hildegarde L. Jameson
2. Date of Death (Month, Day, Year): January 8, 2001
3. Time of Death: 5:05 am

4a. Facility Name *(If not institution, give street and number)*: Calvert County Nursing Center
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 215-44-3045
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 3, 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8414 Flower Avenue, #2
10f. Zip Code: 20912-6731
10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Blueprinter
16b. Kind of Business/Industry: Naval Ordnance Laboratory/US Gov't

17. Father's Neme *(First, Middle, Last)*: Ira L. Leaman
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Annie Stewart

19a. Informant's Neme/Reletionship *(Type, Print)*: Joyce I. Montgomery/ Daughter
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1910 Appalossa Way, Owings, MD 20736-9717

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Parklawn Memorial Park
Dete: Jan 12 2001
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funerel Service Licensee: James E Dooley
22. Name end Address of Feciliity: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. *(Approximate Intervel Between Onset and Death)*

Immediate Cause (Final diseese or condition resulting in death): a. Pneumonia
Due to (or es e consequenca of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
b.
Due to (or es e consequenca of):
c.
Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier:
29c. License number: D51949
29d. Date signed *(Month, Day, Year)*: 1/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Gallihan, MD 110 Hospital Road Suite 310, Prince Frederick, MD 20678

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 11 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0025-001
CJ
Eric D. Jeffries
Amended #4b 1/9/01 nls Allegany Co.
amend item 23a,27,26 per me G791 1/18/01 yr

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00767

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eric Dwain Jeffries
2. Date of Death: Month January Day 01 Year 2001
3. Time of Death: 06:30 P.M.
4a. Facility Name (If not institution, give street and number): 13005 Lois Lane
4b. City, Town, or Location of Death: Flintstone ~~Flinstone~~
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-94-3809
6. Sex: 1☐M 2☐F X
7. Age (In yrs. last birthday): 23 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 26, 1977
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Flintstone
10d. Inside City Limits: 1☐Yes 2☐No X
10e. Street and Number: 13005 Lois Lane
10f. Zip Code: 21530
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): volunteer
16b. Kind of Business/Industry: ministry
17. Father's Name (First, Middle, Last): Wilbert L. Jeffries
18. Mother's Neme (First, Middle, Maiden Surname): Deborah P. (King)
19a. Informant's Name/Relationship (Type, Print): W.L. and D.P. Jeffries parents
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 13005 Lois Lane;Flintstone MD 21530
20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Glendale Cemetery
Date: 1/06/2001
20c. Location - City or Town, State: Flintstone, MD
21. Signature of Funeral Service Licensee: James F Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death)
a. SEIZURE DISORDER
Due to (or as a consequence ot):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence ot):
d.

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Dtd tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy tindings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☒~~Other (Specify)~~ ~~Scene~~
27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined
28a. Date ot Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(a) and manner stated.
29b. Signature and title ot certifier: Dennis J Chutema
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): January 2, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutema 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete tiled (Month, Dey, Year): JAN 04 2001
32. Registrar's Signature: Jeanne D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00768

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Carroll Johnson	Jan 03 2001	1130 Am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Dorchester General Hospital	Cambridge	Dorchester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
222-03-9522	1 [X] M 2 [ ] F	81 Yrs.			Aug. 5, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Dorchester	Hurlock	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6015 Circle Drive	21643	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
7		Farm Worker/Waterman	Agriculture/Oyster

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Ennals	Martha Johnson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Algie Stanley/Friend	PO Box 336, E. New Mkt., MD 21631

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Waugh Cemetery	1/6/01	Cambridge, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael F. Eskow	Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Anoxic Brain Damage	4 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cerebral Vascular Accident	4 days
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M. Falden MD	D26388	JAN 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Falden MD 302 Collins Hurlock md 21643

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 5 2001	▶ Donna G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00769

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH H. KURTZ

2. Date of Death: Month JANUARY Day 9 Year 2001

3. Time of Death: 1:00 AM

4a. Facility Name (If not institution, give street and number): GENESIS ELDER CARE CENTER

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-10-1431

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 2, 1916

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 17000 Norbrook Drive

10f. Zip Code: 20832

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Banker

16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): John Kurtz

18. Mother's Name (First, Middle, Maiden Surname): Helen (Unknown)

19a. Informant's Name/Relationship (Type, Print): Joseph R. Kurtz / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17000 Norbrook Drive, Olney, Maryland 20832

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: 1/10/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: John G. Ruta

22. Name and Address of Facility: Muriel H. Barber Funeral Home, P.O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	2 weeks
Due to (or as a consequence of): b.	Non Small cell Cancer of Lung	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amendhiratta MD

29c. License number: D38262

29d. Data signed (Month, Day, Year): Jan 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr A. Mendhiratta 2401 Research BLVD Suite 340 Rockville MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00770

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERNEST RICHARD KOTH
2. Date of Death (Month, Day, Year): JANUARY 4, 2001
3. Time of Death: 7:30 AM
4a. Facility Name (If not institution, give street and number): BROOKE GROVE ASSISTED LIVING -THE WOODS
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 216 44 3539
6. Sex: 1☒ M 2☐ F
7. Age (in yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT.5,1902
9. Birthplace (State or Foreign Country): WISCONSIN

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: MONTGOMERY VILLAGE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19109 BROOKE GROVE COURT
10f. Zip Code: 20886
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CIVIL ENGINEER
16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name (First, Middle, Last): OTTO ARNOLD KOTH
18. Mother's Name (First, Middle, Maiden Surname): MARY EMMA GALL

19a. Informant's Name/Relationship (Type, Print): CAROL K. THOMAS, DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19109 BROOKE GROVE CT., MONTGOMERY VILLAGE, MD. 20886

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY
Date: 1/05/01
20c. Location - City or Town, State: ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Prostate carcinoma with metastasis — 7 years
Due to (or as a consequence of):
b. Anemia — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia, Cardiomyopathy
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☑ Other (Specify) ASST.LIVING

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dawn Broderick, M.D
29c. License number: D45956
29d. Date signed (Month, Day, Year): January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dawn Broderick M.D 18111 Prince Philip Dr T.12 Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00771

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES T. KIRBY
2. Date of Death Month 01 Day 09 Year 2001
3. Time of Death 8:12 AM
4a. Facility Name (If not institution, give street and number): MALCOLM GROW HOSPT.
4b. City, Town, or Location of Death: SUITLAND
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-76-9115
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-21-55
9. Birthplace (State or Foreign Country): WASH. D.C.

Usual Residence of Decedent

10a. State: MD
10b. County: P. G
10c. City, Town or Location: FORESTVILLE
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 1414 WOODLARK DR.
10f. Zip Code: 20747
10g. Citizen of What Country? USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): PRIVATE INVESTIGATOR
16b. Kind of Business/Industry: SECURITY

17. Father's Name (First, Middle, Last): CHARLES E. KIRBY
18. Mother's Name (First, Middle, Maiden Surname): MARIE KENNER

19a. Informent's Neme/Relationship (Type, Print): LINDA KIRBY/SISTER
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): MARYLAND NATIONAL CEM.
Dete: 1/15/01
20c. Location - City or Town, State: LAUREL, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MO0091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Final diseese or condition resulting in death):
a. CHRONIC CONGESTIVE HEART FAILURE 8 YRS
Due to (or as a consequence of):
b. DILATED CARDIOMYOPATHY 8 YRS

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
Due to (or es a consequence of):
c. ISCHEMIC CARDIOMYOPATHY 8 YRS
Due to (or as a consequence of):
d. INSULIN DEPENDENT DIABETES 36 YRS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was en eutopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 X No
26. Piece of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 X Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.
29b. Signature and title of certifier: David A. Gorray MD. DAVID A. GORRAY.
29c. License number: D 28195
29d. Date signed (Month, Day, Year): 01-10-2001
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): David A. Gorray M.D. 1450 MERCANTILE LANE #217 LARGO, MD. 20774

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00772

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beatrice F. Kaplan

2. Date of Death (Month, Day, Year): January 5, 20001

3. Time of Death: 9:25 AM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 237-56-4371

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 22, 1909

9. Birthplace (State or Foreign Country): MO

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3330 N. Leisure World Blvd., # 902

10f. Zip Code: 20906

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker

16b. Kind of Business/Industry: Civic Organization

17. Father's Name (First, Middle, Last): Ferdinand Fischlowitz

18. Mothar's Name (First, Middle, Maiden Surname): Emma Gad

19a. Informant's Name/Relationship (Type, Print): Dr. Rubin H. Kaplan - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Code): 3330 N. Leisure World Blvd., # 902, Silver Spring, Md 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens

Data: 1/7/2001

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Md. 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Urosepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ G. Arcellano

29c. License number: D42578

29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR.GUL CHABLANI, 11119 ROCKVILLE PIKE,#316 ROCKVILLE,MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

9

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00773

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bonnie Ray Klein

2. Date of Death Month Day Year: January 2nd 2001

3. Time of Death: 9:50 p.m.

4a. Facility Name *(If not institution, give street and number)*: Western Maryland Hospital Center

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-74-9559

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 30, 1940

9. Birthplace *(State or Foreign Country)*: Washington, D. C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 48 Wayside Avenue

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): None; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: None

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: Lewis Klein

18. Mother's Name *(First, Middle, Maiden Surname)*: Evelyn Hess

19a. Informant's Name/Relationship *(Type, Print)*: Carol S. Suker Guardian

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 122 N. Potomac St., Hagerstown, Md. 21740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory

Date: 1/5/01

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street, Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Probable Cardiac Arrhythmia — [illegible]

Due to (or as a consequence of):

b. Probable Acute Myocardial Infarction — [illegible]

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Downs Syndrome, Hypothyroidism, Seizures, Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD

29c. License number: D18019

29d. Date signed *(Month, Day, Year)*: Jan 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vasant Datta, 1500 Pennsylvania Avenue, Hagerstown, MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 04 2001

32. Registrar's Signature: [illegible]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00774

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT HENRY KARLOWA

2. Date of Death Month: JANUARY Day: 1 Year: 2001

3. Time of Death: 7:30PM

4a. Facility Name *(If not institution, give street and number)*: 10905 CASH VALLEY ROAD N.W.

4b. City, Town, or Location of Death: LAVALE

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 219-14-5518

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 11 1925

9. Birthplace *(State or Foreign Country)*: IOWA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: LAVALE

10d. Insida City Limits: 1 [ ] Yas 2 [X] No XX

10e. Street and Number: 10905 CASH VALLEY ROAD N.W.

10f. Zip Coda: 21502

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No

If Yes, Giva Yaar or Datas: 1944-1946

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.)

1 [ ] Yas 2 [X] No *Specify:*

14. Raca - American Indian, Black, White, atc.

Specify: WHITE

15. Decedant's Education *(Specify only highast grada complatad)*

Elementary/Secondary (0-12): 12 +

Collega (1-4or 5+): 4

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: CASUALS INC./OWNER-OPERATOR

16b. Kind of Businass/Industry: CLOTHING/RETAIL

17. Fathar's Nama *(First, Middle, Last)*: ROBERT K. KARLOWA

18. Mothar's Nama *(First, Middle, Maidan Sumama)*: ANNE MARIE WOLTERS

19a. Informant's Name/Ralationship *(Type, Print)*: RUTH CHIARENZA DAUGHTER

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 803 PIEDMONT AVE. CUMBERLAND MARYLAND 21502

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, crematory or othar place)*: HILLCREST CEMETERY

Data: JAN 4 2001

20c. Location - City or Town, Stata: CUMBERLAND MARYLAND

21. Signature of Funaral Service Licensee: Dale L. Merritt

22. Nama and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death):

a. HYPERTENSIVE CARDIOVASCULAR DISEASE — UNKNOWN

Dua to (or as a consaquanca of):

Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last

b. Dua to (or as a consaquanca of):

c. Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy parformad? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Daath *(Check only ona)*

Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA

Othar: 4 [ ] Nursing Homa 5 [X] Rasidanca 6 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowladga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar statad.

29b. Signature and titla of certifiar: Gregg C. Donaldson

29c. Licansa number: D0042054

29d. Data signed *(Month, Day, Year)*: JANUARY 2, 2001

30. Nama and addrass of parson who completad causa of daath (Itam 23a) (Type, Print): DR GREGG C. DONALDSON 10903 CASH VALLEY ROAD N.W. LAVALE MARYLAND 21502

State Registrar

31. Data filad *(Month, Day, Year)*: JAN 03 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

51

MS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00775

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Mary	W.	Kluza	January 1, 2001	10:30PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mariner Health Care of Bethesda	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
345-09-8365	1☐ M 2☒ F	84 Yrs.			October 1, 1916	Kansas

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
209 Halpine Walk Court	20851	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	-	Computer Operator	Banking

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Kasper Wasko	Pauline Struck

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paulette M. Gawel/ Daughter	209 Halpine Walk Court, Rockville, MD 20851

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Resurrection Cemetery	January 6, 2001	Chicago, Illinois

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M00689	Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Abscess	2 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Alzheimer's Disease	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ralph M. Coan M.D.	D01191	January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ralph M. Coan, M.D. 9618 Culver Street, Kensington, Maryland 20895

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 03 2001	G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #5, 1/11/2001,BMW,Montg.Co.

Certificate of Death

Reg. No. 2001 00776

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Benton Keller

2. Date of Death (Month, Day, Year): January 2, 2001

3. Time of Death: 12:25 AM

4a. Facility Name (If not institution, give street and number): Maplewood Park Place Health Care

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-54-~~5937~~ 5387

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 21,1915

9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9707 Old Georgetown Road

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Willard Smith Robinson

18. Mother's Name (First, Middle, Maiden Surname): Alice Judson Wright

19a. Informant's Name/Relationship (Type, Print): Betsy Koepenick Rexroad(Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 Kent Oaks Way-Gaithersburg, Maryland 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 1-2-01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Lloyd L. Wm

22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Stroke

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D42423

29d. Date signed (Month, Day, Year): January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. Robert Mozayeni, M.D., 5530 Wisconsin Avenue, #1208 Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year): JAN 03 2001

32. Registrar's Signature: Donna B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00777

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Carson M. Lyttle

2. Dete of Deeth: Month January Dey 9, Year 2001

3. Time of Death: 11:30PM

4a Facility Neme *(If not institution, give street and number)*: Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 227-07-3994

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthdey)*: 88 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Nov 13, 1912

9. Birthplece *(State or Foreign Country)*: North Carolina

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Prince George's

10c. City, Town or Location: Adelphi

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10415 Knollwood Drive

10f. Zip Code: 20783

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Chemical Engineering

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Jefferson Durant Lyttle

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Cora Andrews Moss

19a. Informent's Name/Reletionship *(Type, Print)*: Katherine L. Lyttle/ Wife

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10415 Knollwood Drive, Adelphi, MD 20783

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Fort Lincoln Cemetery

Dete: Jan 13 2001

20c. Location - City or Town, Stete: Brentwood, MD

21. Signeture of Fe[illegible]erel Servi[illegible] Licensee: Robert D. Lyn[illegible]

22. Neme end Address of Feciliity: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death)

e. Aspiration Pneumonia

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, dete and pleca, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [illegible]

29c. License number: D0014252

29d. Date signed *(Month, Dey, Yeer)*: 1/11/01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Antonio B. Valentin, MD 7313 Hanover Parkway Greenbelt, MD 20770

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrer's Signeture: [illegible] B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00778

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Caroline Lyons
2. Date of Death Month Day Year: January 7, 2001
3. Time of Death: 4:49 AM
4a. Facility Name *(If not institution, give street and number)*: Manor Care Potomac
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 321-07-9855
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 14, 1909
9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11111 Potomac View Dr.
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Christopher Zierke
18. Mother's Name *(First, Middle, Maiden Surname)*: Selma Booth

19a. Informant's Name/Relationship *(Type, Print)*: Bruce D. Lyons/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11111 Potomac View Dr. Potomac, MD. 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King David Memorial
Date: 1/10/01
20c. Location - City or Town, State: Falls Church, VA.

21. Signature of Funeral Service Licensee: D. Kr...
22. Name and Address of Facility: Danzansky-Goldberg Memorial 1170 Rockville Pike Rockville, MD. 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzhiemers Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J Grady
29c. License number: D0038751
29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. Grady 4910 Mass. Ave, N.W. #210 Washington, DC. 20016

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #26, 1/11/2001, BMW, Montg.Co.

Certificate of Death

Reg. No. 2001 00779

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irene Lyddane

2. Date of Death: Month January Day 7, Year 2001

3. Time of Death: 1:00 p.m.

4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 578 12 6433

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 18, 1919

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: CARROLL

10c. City, Town or Location: MT. AIRY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 716 HORPEL DRIVE

10f. Zip Code: 21771

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: PUBLIC HEALTH SERVICE

17. Father's Name (First, Middle, Last): CHARLES B. GOODING

18. Mother's Name (First, Middle, Maiden Surname): EVELYN L. FLETCHER

19a. Informant's Name/Relationship (Type, Print): MAUREEN LYDDANE, DAUGHTER-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 716 HORPEL DRIVE, MT. AIRY, MD. 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): PARKLAWN CEMETERY

Date: 1/11/01

20c. Location - City or Town, State: ROCKVILLE, MD.

21. Signature of Funeral Service Licensee: Muriel H. Barber

22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DEHYDRATION AND MALNUTRITION — DAYS TO WEEKS

Due to (or as a consequence of):

b. FAILURE TO THRIVE — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ALZHEIMERS DEMENTIA — YEARS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: ~~4☐ Nursing Home~~ 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: M.D.

29c. License number: 026499

29d. Date signed (Month, Day, Year): 1-07-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RONALD MILLER, M.D. 4 COLWELL DRIVE, MT. AIRY, MD. 21771

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrar's Signature: Donna B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00780

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn Dolores Luchun
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 5:30 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 198-05-8852
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 16, 1919
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD.
10b. County: Prince Georges
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1927 Merrimac Drive
10f. Zip Code: 20783
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Jasalinas
18. Mother's Name (First, Middle, Maiden Surname): Anna Payous

19a. Informant's Name/Relationship (Type, Print): Robert Luchun / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 Acre Road Millville, Pennsylvania 17846

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — Date: 1/9/01
20c. Location - City or Town, State: Silver Spring, MD.

21. Signature of Funeral Service Licensee: Robert Sumner
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE MYOCARDIAL INFARCTION	~ minutes
Due to (or as a consequence of): b.	END STAGE RENAL DISEASE	~ 2 h
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	DIABETES MELLITUS	years
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. S. Nayar
29c. License number: D-17874
29d. Date signed (Month, Day, Year): 1-6-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. M. NAYAR, MD. 3717-38th AVE COTTAGE CITY, MD 20722

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-40-021
JOHN C. LETCHER
JVW amend item 23a,ptII,27 per me 2/5/01 yf G792

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00781

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN CLIFFORD LETCHER, JR.
2. Date of Death (Month, Day, Year): JANUARY 02, 2001
3. Time of Death: 8:27 P.M.
4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 579-56-4257
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 3, 1944
9. Birthplace (State or Foreign Country): LOUISIANA

Usual Residence of Decedent

10a. State: MD
10b. County: NONE
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 10 CLARKE PLACE
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MEDICAL DOCTOR
16b. Kind of Business/Industry: PRIVATE PRACTICE

17. Father's Name (First, Middle, Last): JOHN CLIFFORD LETCHER
18. Mother's Name (First, Middle, Maiden Surname): MARIAN CHAMBLIN

19a. Informant's Name/Relationship (Type, Print): J. CLIFFORD LETCHER/FATHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1411 MONTAGUE ST., N.W. WASH. D.C. 20011

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY
Date: JAN. 8, 2001
20c. Location - City or Town, State: ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DEVOL FUNERAL HOME 2222 WISCONSIN AVE., N.W. WASH. D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. DILATED CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
LIVER STEATOSIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00782

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEROY H. LEIBEL
2. Date of Death (Month, Day, Year): January 2, 2001
3. Time of Death: 12:30 PM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-20-7362
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 2, 1917
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3500 Preston COurt
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): President/ Owner
18b. Kind of Business/Industry: Dry Cleaning and Laundry Chain

17. Father's Name (First, Middle, Last): Henry Leibel
18. Mother's Name (First, Middle, Maiden Surname): Frances Schutzman

19e. Informant's Name/Relationship (Type, Print): Lois Leibel (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3500 Preston Court, Chevy Chase, MD 20815

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King David Memorial Gdns.
Date: 01/04/01
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: ▶ Nancy A. Pecantic
22. Name and Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 Wisconsin Ave., NW Washington, DC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute anemia
Due to (or as a consequence of):
b. Coronary artery disease — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Parkinson's disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed (Month, Day, Year): January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

GF
1-3-01 V237
Leibel, Leroy
10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00783

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Henry Joseph Legowski
2. Date of Death Month Day Year: January 6, 2001
3. Time of Death: 3:30 am
4a. Facility Name *(If not institution, give street and number)*: 10708 Meadowhill Road
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 141-01-4677
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar 18, 1920
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10708 Meadowhill Road
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW-II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Assistant to the General President
16b. Kind of Business/Industry: International Union of Operating Engineers

17. Father's Name *(First, Middle, Last)*: Konstanty Legowski
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Victoria Bujanowska

19a. Informant's Name/Raiationship *(Type, Print)*: Marianne L. Lambert/ Daughter
19b. Mailing Address *(Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 5003 Brookeway Drive, Bethesda, MD 20816

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or other place)*: Gate of Heaven Cemetery
Date: Jan 11 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Francis J. Collins Funeral Home,Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock or heart failure. List only one causa on aach lina.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)
a. Congestive Heart Failure
Dua to (or as a consequance of):
b. Atherosclerotic Coronary Artery Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa referrad to medical examiner? 1☒ Yes 2☐ No

28. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at the time, date and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner staiad.

29b. Signature and title of certifier: [signature]
29c. License number: D 24886
29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Mark Eig, MD 10801 Lockwood Drive, Silver Spring, MD 20901

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00784

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Christopher Tran-Duy Le

2. Date of Death (Month, Day, Year): January 6, 2001

3. Time of Death: 11:30 am

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: N/A

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: Yrs.

If Under 1 Year: Months; Days: 3

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: Jan 3, 2001

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11205 Cool Breeze Place

10f. Zip Code: 20876

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Tam D. Le

18. Mother's Neme *(First, Middle, Maiden Surname)*: Chau Tran

19a. Intormant's Neme/Reletionship *(Type, Print)*: Tam D. Le / Father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11205 Cool Breeze Place, Germantown, MD 20876

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: Jan 8 2001

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: James E Dailey

22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert tailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alpha Thalassemia Major — 3 days

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

b. Premature Infant — 3 days

Due to (or as a consequence of):

c. Prolonged Hypoxia — 3 days

Due to (or as a consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy tindings aveiiable prior to completion ot cause ot death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner ot Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete ot Injury *(Month, Day Year)*

28b. Time ot Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, term, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0053509

29d. Date signed *(Month, Day, Year)*: 01-06-01

30. Name and address ot person who completed cause ot death (Item 23a) (Type, Print): Alan K. Goldberg, MD 1500 FOREST GLEN RD SILVER SPRING, MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrer's Signature: Anna B. Sachs

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00785

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EUNICE L. LAWSON

2. Date of Death Month Day Year: JANUARY 6, 2001

3. Time of Death: 1000 AM

4a. Facility Name *(If not institution, give street and number)*: 19515 FREDERICK ROAD

4b. City, Town, or Location of Death: GERMANTOWN

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 247 48 5974

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 17, 1929

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residance of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: GERMANTOWN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 19515 FREDERICK ROAD

10f. Zip Code: 20876

10g. Citizen of Whet Country?: UNITED STATES

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Amarican Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 7; College (1-4or 5+): 0

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SOLDERER

16b. Kind of Business/Industry: ENGINEERING

17. Father's Neme *(First, Middle, Last)*: ERNEST MONTGOMERY

18. Mother's Neme *(First, Middle, Meiden Surneme)*: ETHEL FORD

19a. Informent's Neme/Raletionship *(Type, Print)*: PATRICIA M. SHAW , DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18701 CURRY POWDER LANE, GERMANTOWN, MD. 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Nama of cametery, cremetory or other place)*: LAYTONSVILLE CEMETERY

Date: 1/9/01

20c. Location - City or Town, Steta: LAYTONSVILLE, MD.

21. Signeture of Funerei Service Licensee: Muriel H. Barber

22. Nama and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Pert1. Enter tha disease, of complicetions that caused the deeth. Do not entar the mode of dying, such as cardiec or respiretory errest, shock, or haert failure. List only one cause on aech lina.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in deeth) e. Chronic Obstructive pulmonary disease — years

Due to (or es a consequence of):

Sequentielly list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or injury thet initieted evants resulting in deeth) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Thromboembolic disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical exeminer? 1☐ Yes 2☒ No

28. Plece of Deeth *(Check only one)*: Hospitel: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, deta and piece, end due to the ceuse(s) end mennar stated.

29b. Signeture and title of certifier: Alan S Chanales MD

29c. License number: 29453

29d. Dete signed *(Month, Day, Year)*: JANUARY 8, 2001

30. Nema and address of person who completed causa of death (Item 23a) (Type, Print): ALAN S. CHANALES 15115 SHADY GROVE RD ROCKVILLE MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001

32. Registrer's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00786

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carl Chiwen Lai

2. Date of Death Month / Day / Year: January 3, 2001

3. Time of Death: 10:57 pm

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 471-96-1207

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 30, 1923

9. Birthplace *(State or Foreign Country)*: China

Usual Residence of Decedent

10a. State: Virginia

10b. County: Spotsylvania

10c. City, Town or Location: Fredericksburg

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1407 Milestone Drive

10f. Zip Code: 22407

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Professor of Mechanical Eng

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Tacai Lai

18. Mother's Name *(First, Middle, Maiden Surname)*: Fozhao Zhong

19a. Informant's Name/Relationship *(Type, Print)*: Shelley Guo Lai (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1407 Milestone Drive Fredericksburg,Virginia 22407

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: Jan.9, 2001

20c. Location - City or Town, State: Silver Spring,Maryland

21. Signature of Funeral Service Licensee: James S Darby

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia-Bacterial

Due to (or as a consequence of):

c. Metastatic Pancreatic Cancer

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

Liver Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gary P. Zaloga MD

29c. License number: D 0033235

29d. Date signed *(Month, Day, Year)*: January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary P. Zaloga, MD 8600 Old Georgetown Road, Bethesda, MD 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 9 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Lai, Carl 3 Jan 01 22:57

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00787

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLIFFORD FREDERICK LaROCHELLE
2. Date of Death: Month January Day 1, Year 2001
3. Time of Death: 7:50 PM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-44-7728
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 22, 1935
9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Accokeek
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 601 Farmington Road West
10f. Zip Code: 20607
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1953-1961
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Warehouse Manager
16b. Kind of Business/Industry: Advertisement

17. Father's Name (First, Middle, Last): Eugene William LaRochelle
18. Mother's Name (First, Middle, Maiden Surname): Doris Lorraine Hutton

19a. Informant's Name/Relationship (Type, Print): Edwardina M. LaRochelle/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 601 Farmington Road West, Accokeek, MD 20607

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Huntt Crematory
Date: 01-04-2001
20c. Location - City or Town, State: Waldorf, Maryland

21. Signature of Funeral Service Licensee: JOHN P. KNISLEY M01164
22. Name and Address of Facility: The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D53885
29d. Date signed (Month, Day, Year): 1/3/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VENKAT RAMANAN 7501 SURRATTS ROAD #307 CLINTON MD 20735

State Registrar

31. Date filed (Month, Day, Year): JAN 03 2001
32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

mew

LaRochelle, Clifford Patel, S. 1950 - 01/01/01 4935603

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00788

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Kenneth Mulligan
2. Date of Death (Month, Day, Year): Jan. 5 2001
3. Time of Death: 0045
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 356-01-3566
6. Sex: 1 ☐ M 2 ☐ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 31 1911
9. Birthplace (State or Foreign Country): Rhode Island

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4615 Hunt Ave.
10f. Zip Code: 20815-5424
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Personnel Management
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): James Alexander Mulligan
18. Mother's Name (First, Middle, Maiden Surname): Margaret Fitzsimmons

19a. Informant's Name/Relationship (Type, Print): Louise L. Mulligan/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4615 Hunt Ave., Chevy Chase, MD 20815-5424

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Uniformed Services Univer
Date: Jan. 8 2000
20c. Location - City or Town, State: Bethesda, MD

21. Signature of Funeral Service Licensee: Kevin A Moody
22. Name and Address of Facility: Rapp Funeral & Cremation Services
Stephen D. Lohrmann, 933 Gist Ave.
Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia Community Acquired — 5 Days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Multiple Myeloma
Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: James Foster MD
29c. License number: D04179
29d. Date signed (Month, Day, Year): 1/07/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James T. Foster M.D. 5530 Wisc Av. Chevy Chase MD

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001
32. Registrar's Signature: Dawn B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Mulligan, James 1-5-01 0045
Mulligan, James 1/5/01 0045 AM
12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00789

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRIET LOUISE MONGELLUZZO

2. Date of Death Month: ~~JANUARY~~ Day: 07 Year: 2001

3. Time of Death: 1810

4a. Facility Name *(If not institution, give street and number)*: 1101 AGNEW DRIVE

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 193-03-6879

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: August 12, 1915

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1101 Agnew Drive

10f. Zip Coda: 20851

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT usa ratired)*: Secretary

16b. Kind of Business/Industry: Defense Subcontractor

17. Father's Name *(First, Middle, Last)*: Laird Charles Zimmerman

18. Mother's Nama *(First, Middla, Maidan Surname)*: Ressie Jane Rairigh

19a. Informant's Name/Ralationship *(Type, Print)*: James F. Mongelluzzo/Husband

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1101 Agnew Drive, Rockville, Maryland 20851

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or othar place)*: Gate of Heaven Cemetery

Data: January 11,2001

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: [signature] M00846

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse *on* each line.

Approximate Intarvel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Disease or injury that initiated avants resulting in death) Lest

b. Dua to (or es e consaquence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of daath? 1☐ Yes 2☒ No

25. Was cese referrad to medical examiner? 1☒ Yes 2☐ No

26. Plece of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Rasidence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and dua to tha ceuse(s) end manner as stated. 2☒ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurred et tha time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD (ONE)

29c. Licensa number: D15236

29d. Date signed *(Month, Day, Year)*: JANUARY 07, 2001

30. Name end eddrass of person who completed cause of death (Item 23e) (Type, Print): CARL I. MARGOLIS, MD (ONE) 11125 Rockville Pike, Rockville, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 00790

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Francis Michael Monahan
2. Date of Death Month Day Year: January 8, 2001
3. Time of Death: 11:19 pm
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 049-10-7160
6. Sex: 1 X M 2 ☐ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 24, 1912
9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 10513 Gilmoure Drive
10f. Zip Code: 20901
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Security Guard
16b. Kind of Business/Industry: Pepco
17. Father's Name *(First, Middle, Last)*: Michael F. Monahan
18. Mother's Name *(First, Middle, Maiden Surname)*: Julia Hurley
19a. Informant's Name/Relationship *(Type, Print)*: Helen L. Monahan / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10513 Gilmoure Drive, Silver Spring, MD 20901
20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: Jan 12 2001
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Severe Congestive Heart Failure	4 weeks
Due to (or as a consequence of): b.	Acute Myocardial Infarction	4 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Coronary Artery Disease	18 months
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Lymphoma

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Phillip W. Poth, M.D.
29c. License number: D22308
29d. Date signed *(Month, Day, Year)*: January 5th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Phillip W. Poth, M.D. 5013 Flower Ave., Silver Spring, Md. 20901

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

VOID

CERTIFICATE ##

01-00791

SEE

CERTIFICATE ##

00-43510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00792

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur N. Mindling
2. Date of Death (Month, Day, Year): January 6, 2001
3. Time of Death: 3:00 am
4a. Facility Name (If not institution, give street and number): 1809 Sanford Road
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 497-05-7781
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.6,1916
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1809 Sanford Road
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Charles Frederick Mindling
18. Mother's Name (First, Middle, Maiden Surname): Berta Mae Humiston

19a. Informant's Name/Relationship (Type, Print): Helen M. Mindling (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1809 Sanford Road Silver Spring,Maryland 20902

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Jan.9, 2001
20c. Location - City or Town, State: Silver Spring,Maryland

21. Signature of Funeral Service Licensee: Robert E Ramsey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. Myelodysplastic Syndrome

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Transient Ischemic Attacks

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD.
29c. License number: D54347
29d. Date signed (Month, Day, Year): JANUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEERAJ CHOPRA 121 CONGRESSIONAL LANE, #409 (SUITE) ROCKVILLE, MARYLAND 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00793

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROY MALGRAM MILLER
2. Date of Death (Month, Day, Year): January 7, 2001
3. Time of Death: 3:00 PM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-36-0559
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 6, 1929
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11405 Locustdale Terrace
10f. Zip Code: 20876
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Special Events Coordinator
16b. Kind of Business/Industry: Coca Cola Company

17. Father's Name (First, Middle, Last): Frank Miller
18. Mother's Name (First, Middle, Maiden Surname): Rosa Haddock

19a. Informant's Name/Relationship (Type, Print): Margaret Vivian Miller, Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11405 Locustdale Terrace, Germantown, MD 20876

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park
Date: Jan 10, 2001
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	7 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D35635
29d. Date signed (Month, Day, Year): January 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan, MD 18111 Prince Philip Dr. Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00794

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSALIE MILLER
2. Date of Death (Month, Day, Year): JAN. 5 2001
3. Time of Death: 3:30 AM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-28-1807
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 5, 1926
9. Birthplace (State or Foreign Country): WASHINGTON D.C.

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 15316 PINE ORCHARD DRIVE #3K
10f. Zip Code: 20906
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HARRY RINIS
18. Mother's Name (First, Middle, Maiden Surname): IDA STATSKY

19a. Informant's Name/Relationship (Type, Print): SAMUEL MILLER/ HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15316 PINE ORCHARD DR.#3K SILVER SPRING,MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEMORIAL GARDEN
Date: 01/07 2001
20c. Location - City or Town, State: FALLS CHURCH,VA

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS,INC. 1170 ROCKVILLE PIKE,ROCKVILLE,MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC BREAST CANCER
Due to (or as a consequence of): to BONE MARROW — 2 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Carolyn B Hendricks MD
29c. License number: D37236
29d. Date signed (Month, Day, Year): JANUARY 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CAROLYN B HENDRICKS MD 6410 ROCKLEDGE DR #305 BETHESDA MD

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

ROSALIE MILLER 3:30 AM 1/5/01

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 19A PER INFORMANT G792 2-1-01 WB

Certificate of Death

Reg. No. 2001 00795

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patricia G. McMurrough
2. Date of Death (Month, Day, Year): January 8, 2001
3. Time of Death: 2:05 pm
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Rehabilitation and Nursing Center
4b. City, Town, or Location of Death: Burtonsville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 199-24-4940
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 25, 1930
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10422 Fawcett Street Apt 1
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: John Owen McMurrough
18. Mother's Name *(First, Middle, Maiden Surname)*: Johanna Carey

19a. Informant's Name/Relationship *(Type, Print)*: Julia McMurrough, ~~HCS~~ CSC / Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10422 Fawcett Street Apt 1, Kensington, MD 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: Jan 12 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: John E. Barber
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Diabetes Mellitus

Due to (or as a consequence of):
c. Atrial Fibrillation

Due to (or as a consequence of):
d. Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Breast Cancer

Ulcerative Colitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Seidman MD
29c. License number: D -0037801
29d. Date signed *(Month, Day, Year)*: January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Aimee J. Seidman , MD 11906-G Darnestown Road, N. Potomac, MD 20878

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: Donna B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00796

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Clement McDonnell

2. Date of Death (Month, Day, Year): January 6, 2001

3. Time of Death: 9:30 pm

4a. Facility Name (If not institution, give street and number): Alfred House #4

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 504 28 8381

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 18, 1912

9. Birthplace (State or Foreign Country): South Dakota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15100 Interlachen Drive, Apartment #406

10f. Zip Code: 20906

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 1944 - 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Collega (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Federal Employee

16b. Kind of Business/Industry: Department of Housing & Urban Development

17. Father's Name (First, Middle, Last): James Edward McDonnell

18. Mother's Name (First, Middle, Maiden Surname): Lucy Ann Ryan

19a. Informant's Name/Relationship (Type, Print): Marie R. McDonnell/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15100 Interlachen Dr.,Apt #406,Silver Spring,MD20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: January 9, 2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Generalized Arteriosclerosis

Due to (or as a consequence of): Cerebrovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of): Recent Cerebro vascular accidents

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia, Poor Nutrition

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D25410

29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Oliver Lawless, 18111 Prince Phillip Drive, #126, Olney, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00797

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ann W. Matthews

2. Data of Death Month Day Year: January 10, 2001

3. Time of Death: 3:25A.M.

4a. Facility Name (If not institution, give street and number): Forest Glen Nursing & Rehab. Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-40-1311

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 26, 1918

9. Birthplace (State or Foreign Country): Wisconsin

Usual Residence of Decedent

10a. State: none

10b. County: none

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1329 21st Street, N.W.

10f. Zip Code: 20036

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Law Firm

17. Father's Name (First, Middle, Last): Matthew Wisnewski

18. Mother's Nama (First, Middle, Maiden Surname): Antonia Raczniewski

19a. Informant's Name/Relationship (Type, Print): Joseph McManus/ Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1329 21st Street, N.W. Wash. D.C. 20036

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery | Data: Jan.13, 2001

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: John F. DeVol

22. Nama and Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash.D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on aech line.

Approximata Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Acute Myocardial Infarct — Sudden

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case refarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Deta of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Myron L. Lenkin

29c. License number: D06674

29d. Data signed (Month, Day, Year): Jan. 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Myron L. Lenkin, M.D. 2309 Shorefield Road, Wheaton, Maryland 20907

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signatura: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 6

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00798

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Matney
2. Date of Death Month Day Year: January 8, 2001
3. Time of Death: 4:00 pm
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 714-16-1756
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 6, 1910
9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Florida
10b. County: Collier
10c. City, Town or Location: Marco Island
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 801 West Elkcam Circle, C-3
10f. Zip Code: 34145
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Labor Analyst
16b. Kind of Business/Industry: Dept. of Labor
17. Father's Name *(First, Middle, Last)*: William H. Matney
18. Mother's Name *(First, Middle, Maiden Surname)*: Frances Robinson
19a. Informant's Name/Relationship *(Type, Print)*: Esther M. Matney / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 801 West Elkcam Circle, C-3, Marco Island, Fla. 34145
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery
Date: 1/13/01
20c. Location - City or Town, State: Frederick, Maryland
21. Signature of Funeral Service Licensee: Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — 10 days

Due to (or as a consequence of):
b. MULTIPLE STROKE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CEREBRO VASCULAR DISEASE
Due to (or as a consequence of):
d. ARTERIOSCLEROTIC CARDIO. VASCULAR DIS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
RENAL FAILURE
PROSTATE CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

30+1

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Greg I. Smith M.D. VAMA
29c. License number: D10587
29d. Date signed *(Month, Day, Year)*: 1/9/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH, M.D. VICE-PRES MED AFFAIR, FREDERICK MEM. HOSP. FREDERICK, MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00799

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Hartnett Marklin
2. Date of Death Month / Day / Year: January 5, 2001
3. Time of Death: 11:30PM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-44-9461
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 96 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 17, 1904
9. Birthplace *(State or Foreign Country)*: Ireland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4619 Maple Avenue
10f. Zip Code: 20814
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yeer or Detes:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Blеck, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): — Collega (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT use retired)*: Registered Nurse
16b. Kind of Businass/Industry: Healthcare

17. Father's Name *(First, Middle, Last)*: Donald Hartnett
18. Mothar's Nama *(First, Middle, Maiden Sumame)*: Ellen O'Conner

19a. Informant's Name/Ralationship *(Type, Print)*: Elizabeth Marders/Daughter
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 9975 Dothian Place, Newburg, Maryland 20664

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar placa)*: Gate of Heaven Cemetery — Date: January 9, 2001
20c. Location - City or Town, Stata: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: [signature] M01126
22. Nama and Addrass of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. — Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death):
a. Cerebral Vascular Accident
Dua to (or as a consequenca of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last
b. Dua to (or as a consequanca of):
c. Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.
Diabetes
Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Wara autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☑ No

26. Place of Death *(Check only ona)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☑ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of certifiar: Teresa Allen MD
29c. License number: D0034795
29d. Date signed *(Month, Day, Year)*: 1-6-2001

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): 6525 Belcrest Road Hyattsville Maryland

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 08 2001
32. Registrar's Signatura: Serena B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

G.F.

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00800

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arthur Margulies

2. Date of Death (Month, Day, Year): January 2, 2001

3. Time of Death: 3:52 A.M.

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 054-16-6702

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 19, 1915

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11700 Old Columbia Pike, # 1715

10f. Zip Code: 20904

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW 2 Army

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: General Contractor

16b. Kind of Business/Industry: Building

17. Father's Name *(First, Middle, Last)*: David Margulies

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Fuhrer

19a. Informant's Name/Relationship *(Type, Print)*: J. Richard Margulies - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17925 Ednor View Terrace, Ashton, Maryland 20861

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Lebanon Cemetery

Date: 1/4/2001

20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic Cardionary Apathy

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Urosepsis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Alan R. Segal

29c. License number: D52261

29d. Date signed *(Month, Day, Year)*: January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan R. Segal, M. D. 1299 Lamberton Drive, Silver Spring, Maryland 20902-3411

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: ▶ [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00801

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES MANDELL
2. Date of Death (Month, Day, Year): JANUARY 4, 2001
3. Time of Death: 7:15 PM
4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 067-09-3932
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-31-1912
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6105 MONTROSE ROAD
10f. Zip Code: 20832
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: LEGAL

17. Father's Name (First, Middle, Last): MICHAEL AGRESS
18. Mother's Name (First, Middle, Maiden Surname): MOLLY "UNKNOWN"

19a. Informant's Name/Relationship (Type, Print): BURTON L. SCHLISSEL/SON IN LAW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12105 LONG RIDGE LANE, BOWIE, MARYLAND 20715

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH DAVID MEMORIAL PARK
Date: JAN 8, 2001
20c. Location - City or Town, State: HOLLYWOOD, FLORIDA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Vascular Accident	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gary B. Wilks
29c. License number: D0055258
29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary B. Wilks, MD 6121 Montrose Road Rockville Maryland 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

5 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00802

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Scott John Mancuso
2. Date of Death (Month, Day, Year): January 9, 2001
3. Time of Death: 11:25 am
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-58-7522
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 45 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 15, 1955
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 15205 Candytuft Lane
10f. Zip Code: 20853
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Cardiopulminary Tech
16b. Kind of Business/Industry: Health/ Medical

17. Father's Name (First, Middle, Last): Walter E. Mancuso
18. Mother's Name (First, Middle, Maiden Surname): Evelyn C. Herzog

19a. Informant's Name/Relationship (Type, Print): Nancy H. Mancuso / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15203 Candytuft Lane, Rockville, MD 20853

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Jan 12 2001
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee? ▶ Eric S Sparks
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Anoxic Brain Injury — 2 days
Due to (or as a consequence of):
b. Hypoxemic Respiratory Failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
OSstructive sleep Apnea

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D51908
29d. Date signed (Month, Day, Year): January 9 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul B. Masciara MD 18111 Prince Phillip Drive Olney Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: ▶ Eric S. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00803

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HERBERT MAIMAN

2. Date of Death Month Day Year: JAN 7, 2001

3. Time of Death: 10:20 PM

4a. Facility Name *(If not institution, give street and number)*: CASEY HOUSE

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 066-01-3580

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC 03, 1910

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: BETHESDA

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5804 WILMETT ROAD

10f. Zip Code: 20817

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ENGINEER

16b. Kind of Business/Industry: US GOVERNMENT

17. Father's Name *(First, Middle, Last)*: HARRY MAIMAN

18. Mother's Name *(First, Middle, Maiden Surname)*: IDA GORSKY

19a. Informant's Name/Relationship *(Type, Print)*: LOIS A. MAIMAN/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5804 WILMETT ROAD, BETHESDA, MARYLAND 20814

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MONMOUTH FIELDS CEMETERY

Date: JAN10, 2001

20c. Location - City or Town, State: WEST LONG BEACH, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL VASCULAR ACCIDENT — MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

SEIZURE DISORDER

ASPIRATION DISORDER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* HOSPICE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. P. Libre MD

29c. License number: D09470

29d. Date signed *(Month, Day, Year)*: JANUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EUGENE P. LIBRE, MD 10400 CONNECTICUT AVE, KENSINGTON, MD 20895

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00804

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERTA CHEATHAM MACKEY

2. Date of Death: Month JAN. Day 11, Year 2001

3. Time of Death: 4:00 AM

4a. Facility Name (If not institution, give street and number): 10807 WOODLAWN BLVD.

4b. City, Town, or Location of Death: UPPER MARLBORO

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 203-26-5829

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 15,1934

9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD.

10b. County: PRINCE GEORGES

10c. City, Town or Location: UPPER MARLBORO

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10807 WOODLAWN BLVD.

10f. Zip Code: 20774

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): ROBERT FOSTER

18. Mother's Neme (First, Middle, Meiden Sumeme): LEORA GROOMS

19a. Informant's Name/Relationship (Type, Print): LINDA CHEATHAM/DAUGHTER

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): CHAMBERS CREMATORY

Date: 1/11/01

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MO0091

22. Name and Address of Facility: 5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES,P.A., RIVERDALE, MD.20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence ol):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

b. LEIOMYOSARCOMA OF THE UTERUS

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place ot Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Menner ol Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date ol Injury (Month, Day Year)

28b. Time ol Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Hawkins

29c. License number: D19757

29d. Date signed (Month, Day, Year): JAN. 11, 2001

30. Name and address ol parson who completed cause of deeth (Item 23a) (Type, Print): MICHAEL J. HAWKINS, M.D. 110 IRVING ST. N.W. SUITE C-2151, WASHINGTON,D.C. 20010

State Registrar

31. Date tiled (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00805

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: GERTRUDE WILKS MACEY

2. Dete of Death — Month: January Dey: 01 Year: 2001

3. Time of Death: 0430

4e Facility Neme *(If not institution, give street and number)*: 5656 Bethlehem Rd.

4b. City, Town, or Location of Death: Preston

4c. County of Deeth: Caroline

Funeral Director

5. Social Security Number: 213-26-6264

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Yeer — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth *(Month, Day, Yeer)*: Feb. 5 1927

9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Caroline

10c. City, Town or Location: Preston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5656 Bethlehem Rd.

10f. Zip Code: 21655

10g. Citizen of Whet Country?: U.S.A.

11. Merital Stetus: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*

Elementery/Secondary (0-12): 11

College (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Neme *(First, Middle, Last)*: Gustav Wilks

18. Mother's Nama *(First, Middle, Meiden Surname)*: Mabel LeMarquand

19e. Informent's Neme/Reletionship *(Type, Print)*: George H. Macey-husband

19b. Meiling Address *(Straet and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 5656 Bethlehem Rd., Preston, MD 21655

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Remeval from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nema of cemetery, cremetory or other piece)*: Parkwood Cemetery

Deta: 1/5/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Kenneth R Thomas Jr

22. Neme end Address of Facility: Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or raspiretory errest, shock, or heert feilure. List only ona cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel diseasa or condition resulting in death)

a. Renal Failure — 4 months

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Entar Underlying Cause (Disaese or injury thet initiated evants resulting in death) Last

b. Aortic Stenosis — 5 years

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evaileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only ona)*

Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Homa 5☒ Residance 8☐ Other *(Specify)*

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, streat, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, deta and piece, and due to the ceuse(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Karen Moffett MD

29c. License number: D51639

29d. Date signed *(Month, Dey, Year)*: 01/01/01

30. Neme and address of person who compiated cause of deeth (Item 23e) (Type, Print): Karen Moffett, MD Daffin Lane, Denton, MD 21629

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 02 2001

32. Registrer's Signeture: Jenne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00806

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Naomi Sarah MADES

2. Date of Death — Month: January Day: 2 Year: 2001

3. Time of Death: 2035

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 577-01-3158

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 10 1917

9. Birthplace (State or Foreign Country): Wash. D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 931 Hamilton Blvd.

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Her own home

17. Father's Name (First, Middle, Last): Charles H. Quigg

18. Mother's Name (First, Middle, Maiden Surname): Marguerite Hunter

19a. Informant's Name/Relationship (Type, Print): Charles F. Mades - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17223 Cloverleaf Road Hagerstown, Maryland 21740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory — Date: 1/3/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: ▶ Scott Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular accident, ischemic heart disease, renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Cynthia Kuttner-Sands, MD

29c. License number: D47451

29d. Date signed (Month, Day, Year): January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Williamsport Nursing Home Cynthia Kuttner-Sands, MD 154 N. Artizan Street, Williamsport, Maryland 21795

State Registrar

31. Date filed (Month, Day, Year): JAN 04 2001

32. Registrar's Signature: Deanna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Mades, Naomi Sarah

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00807

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Thomas Mundy
2. Date of Death: Month January, Day 3, Year 2001
3. Time of Death: 4:20 A.M.
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 715-10-6733
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Oct. 12, 1914
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 419 Russell Avenue #111
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No. If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Consulting Engineer
16b. Kind of Business/Industry: Engineering

17. Father's Name (First, Middle, Last): Andrew Jackson Mundy
18. Mother's Name (First, Middle, Maiden Surname): Edweenia Johnson

19a. Informant's Name/Relationship (Type, Print): Patricia S. Mundy / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 419 Russell Ave. #111 Gaithersburg, Md. 20877

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Jan 4, 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cerebrovascular accident — days

Due to (or as a consequence of):
b. atrial fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
colon cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: [signature]
29c. License number: 20148
29d. Date signed (Month, Day, Year): JANUARY 3, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Dalinsky MD - 911 Russell Ave. Gaithersburg Md.

State Registrar

31. Date filed (Month, Day, Year): JAN 05 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00808

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Guillermina Mazariegos
2. Date of Death Month Day Year: Jan. 2, 2001
3. Time of Death: 10:15 AM
4a. Facility Name *(If not Institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-88-5343
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Jun. 25 1946
9. Birthplace *(State or Foreign Country)*: Guatemala

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Mt.Rainier
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4018 35th Street
10f. Zip Code: 20712
10g. Citizen of What Country?: Guatemala

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yas 2☐ No *Specify:* Guatemalan
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 0; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress
16b. Kind of Businass/Industry: Food Service

17. Father's Name *(First, Middla, Last)*: Paulino Alarcon
18. Mother's Name *(First, Middle, Meiden Surneme)*: Octavia Coronado

19a. Informant's Name/Relationship *(Type, Print)*: Carlos E. Mazariegos/Husband
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4018 35th Street, Mt. Rainier, MD 20712

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other pleca)*: Metropolitan Crematory
Date: Jan. 4 2001
20c. Location - City or Town, State: Alexandria, VA

21. Signatura of Funeral Sarvice Licensee: ▶ J. Ken Skiles
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Entar the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

Approximate Intarval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HEPATIC ENCEPHALOPATHY
Due to (or as a consequance of):
b. HEPATIC FAILURE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated events resulting in daath) Last
Due to (or as a consequence of):
c.
Due to (or as a consaquence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
COAGULOPATHY
SEPSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residanca 6☐ Other *(Specify)*
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determinad
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and dua to tha causa(s) and mannar stated.
29b. Signature and title of certifier: ATTENDING PHYSICIAN
29c. License number: D42749
29d. Date signed *(Month, Dey, Year)*: 1/2/01
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND NWADIUKO 9831 GREENBELT RD STE 104 LANHAM MD 20706

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filad *(Month, Dey, Year)*: JAN 05 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

VOID

CERTIFICATE ⌘

01-00809

SEE

CERTIFICATE ⌘

00-43540

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00810

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wai Chan Ng

2. Date of Death Month Day Year: January 5, 2001

3. Time of Death: 5:05am

4a. Facility Name *(If not institution, give street and number)*: Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-96-4402

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 45 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov.22,1955

9. Birthplace *(State or Foreign Country)*: Malaysia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14201 Wolf Creek Place Apt. #2

10f. Zip Code: 20906

10g. Citizen of What Country?: Malaysia

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Yee Ng

18. Mother's Name *(First, Middle, Maiden Surname)*: Hon Woo

19a. Informent's Name/Relationship *(Type, Print)*: Choo H. Tan/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14201 Wolf Creek Pl. Apt.#2 Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: 1/7/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Anthony S. DeMeo

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma — 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Breast Cancer — 2 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. P. Libre MD

29c. License number: D09470

29d. Date signed *(Month, Day, Year)*: January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene P. Libre, MD 10400 Connecticut Ave. Kensington, MD 20895

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00811

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Olga Neilson
2. Date of Death Month Day Year: January 4, 2001
3. Time of Death: 6:15P.

4a Facility Name *(If not institution, give street and number)*: 5011 Edgewood Road
4b. City, Town, or Location of Death: College Park
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-26-5612
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March30,1924
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5011 Edgewood Road
10f. Zip Code: 20740
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Andrew W. Hungo
18. Mother's Name *(First, Middle, Maiden Surname)*: Julia Kercezman

19a. Informent's Name/Relationship *(Type, Print)*: Barbara Knickelbein - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8078 Foxwell Road Glen Burnie, Maryland 21061-6351

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Fort Lincoln Cemetery
Date: 1/9/2001
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	1-4-01
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Ischemic Heart Disease	8-27-99
Due to (or as a consequence of):		
c.	Diabetes Mellitus	10-2-78
Due to (or as a consequence of):		
d.	Azotaemia	4-4-96

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D0013668
29d. Date signed *(Month, Day, Year)*: January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Azher Hussain, M.D. 4917 Edgewood Road College Park, Maryland 20740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00812

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TYRIQ CHRISTIAN NEWMAN
2. Date of Death (Month, Day, Year): JAN. 2, 2001
3. Time of Death: 1:00 PM
4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: NONE
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days: 9
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 24, 2000
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGES
10c. City, Town or Location: CAPITOL HEIGHTS
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 11 CINDY LANE, APT. #303
10f. Zip Code: 20743
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): NONE; College (1-4or 5+): NONE
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NONE - INFANT
16b. Kind of Business/Industry: NONE - INFANT

17. Father's Name (First, Middle, Last): TYRONE JERMAINE NEWMAN
18. Mother's Name (First, Middle, Maiden Surname): MONIQUE ANAYA EVANS

19a. Informant's Name/Relationship (Type, Print): MONIQUE A. EVANS/MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 CINDY LANE, APT. #303, CAPITOL HEIGHTS, MD 20743

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PGHC
Date: 1-04
20c. Location - City or Town, State: CHEVERLY MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: PGHC 3001 Hospital Dr

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. RENAL FAILURE
Due to (or as a consequence of):
b. SEPTICEMIA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. EXTREME PREMATURITY
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Antoine K. Fomufod, MD
29c. License number: D16239
29d. Date signed (Month, Day, Year): 01/03/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANTOINE K. FOMUFOD M.D., 3001 HOSPITAL DR. CHEVERLY, MD 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00813

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD T. NICHOLS SR.

2. Date of Death (Month, Day, Year): JANUARY 2, 2001

3. Time of Death: 7:15 PM

4a. Facility Name (If not institution, give street and number): 610 WEST PATRICK STREET, APT. # 4

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 220 58 7817

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 5, 1953

9. Birthplace (State or Foreign Country): WASHINGTON, D.C.

Usual Residence of Decedent

10a. State: MD.

10b. County: FREDERICK

10c. City, Town or Location: FREDERICK

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 610 WEST PATRICK STREET, APT. #4

10f. Zip Code: 21701

10g. Citizen of What Country? UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DRY WALL CONTRACTOR

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): JOHN KEMP

18. Mother's Name (First, Middle, Maiden Surname): EVELYN TRIGGER

19a. Informant's Name/Relationship (Type, Print): EDWARD TIMOTHY NICHOLS, II, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 316 S. JEFFERSON ST., FREDERICK, MD. 21701

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY

Date: 1/06/01

20c. Location - City or Town, State: ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber

22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. sudden cardiac death

Due to (or as a consequence of):

b. atherosclerotic heart disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. high cholesterol

Due to (or as a consequence of):

d. smoking

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☒ **Yes** 2 ☐ **No** 3 ☐ **Probably** 4 ☐ **Unknown**

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dale Heitzig MD

29c. License number: D53129

29d. Date signed (Month, Day, Year): 1/4/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DALE HEITZIG MD 610 SOLAREX CT FREDERICK MD 21703

State Registrar

31. Date filed (Month, Day, Year): JAN 04 2001

32. Registrar's Signature: ▶ Brenda G. Sparks

2

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00814

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margie L. Nearhoof

2. Date of Death Month Day Year: January 1, 2001

3. Time of Death: 2:40 P.M.

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 390-22-6225

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 2, 1928

9. Birthplace *(State or Foreign Country)*: Wisconsin

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13538 Vandalia Drive

10f. Zip Code: 20853

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cashier

16b. Kind of Business/Industry: Grocery

17. Father's Name *(First, Middle, Last)*: Delbert Cornell

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Rynes

19a. Informant's Name/Relationship *(Type, Print)*: Lee W. Nearhoof, Sr. - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13538 Vandalia Drive, Rockville, Maryland 20853

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory, Inc.

Date: 1/3/01

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Chronic Obstructive Pulmonary Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Colon Carcinoma

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D34472

29d. Date signed *(Month, Day, Year)*: January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lynne D. Diggs, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 2001

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #20b, 1/5/2001, GF, Montg.Co. *Certificate of Death* Reg. No. 2001 00815

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine Swett Osgood
2. Date of Death Month/Day/Year: January 3, 2001
3. Time of Death: 2:30 PM
4a. Facility Name *(If not institution, give street and number)*: 5480 Wisconsin Avenue #1123
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 030-14-3598
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 102 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: February 22, 1898
9. Birthplace *(State or Foreign Country)*: New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5480 Wisconsin Avenue #1123
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Public/Private School

17. Father's Name *(First, Middle, Last)*: Lotus Aramand Swett
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Catherine McCloy

19a. Informent's Neme/Reietionship *(Type, Print)*: Beth Osgood Chanock/Daughter
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7001 Longwood Drive, Bethesda, Maryland 20817

20a. Method of Disposition: 1☐ Buriai 2☒ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Montgomery Crematorium, Inc.
Date: January 4, ~~2000~~ 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Michael S. Huggins M00846
22. Neme and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finai disease or condition resulting in death)
a. Cardiac Arrythmia — 30 Minutes

Due to (or as a consequence of):
b. Normal Aging Process — Years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
c. Due to (or es e consequenca of):
d. Due to (or es e consequenca of):

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert f.: Failure to Thrive

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: E. A. Libre MD
29c. License number: D09470
29d. Date signed *(Month, Dey, Year)*: January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene Libre, M.D., 10400 Connecticut Avenue #606, Kensington, Maryland 20895-3992

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001
32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

GF

10

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00816

Amend #23a-1, 1/9/2001, BMW, Montg.Co.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Anita		Postal	January 6 2001	6:18 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-50-3522	1☐ M 2☒ F	63 Yrs.			July 30, 1937	Wash., DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
700 Greyrock Drive	20910	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Abraham Zitomer	Celia Miller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Albert E. Postal, Husband	700 Greyrock Dr., Silver Spring, MD 20910

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Judean Memorial Gardens	1/7/01	Olney, MD

21. Signature of Funeral Service Doctor	22. Name and Address of Facility
Joyce E. Torchinsky	Jefferson Funeral Chapel 5755 Castlewellan Dr., Alexandria, VA 22315

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. cryptogenic cirrhosis	3 years
Due to (or as a consequence of):	b. gastro intestinal bleed	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Renal failure	3 weeks
Due to (or as a consequence of):	d. ~~aspiration~~ Aspiration pneumonia	3 weeks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
Robert Roberts M.D.	RES000	January, 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TODD Puterwitz 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 9 2001	Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00817

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRVING PITTLEMAN
2. Data of Death Month Day Yaar: Jan. 11, 2001
3. Tima of Death: 1:40 AM
4a. Facility Nama (If not institution, giva street and number): Hebrew Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-28-0313
6. Sex: 1☐ M 2☐ F — X
7. Aga (In yrs. last birthday): 93 Yrs. — If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): May 26, 1907
9. Birthplace (State or Foraign Country): Austria

Usual Residence of Decedent

10a. Stata: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 6121 Montrose Rd.
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced — X
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — X — If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No — X — Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Liquor Salesman
16b. Kind of Businass/Industry: Private

17. Fathar's Nama (First, Middle, Last): Joseph Pittleman
18. Mothar's Nama (First, Middle, Maiden Sumama): Unknown

19a. Informant's Neme/Ralationship (Type, Print): Kaye- daughter Suellen
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 42 Christopher Ave.,Gathersborg,MD 20879

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Plece of Disposition (Nama of cematary, cremetory or other piece): Judean Memorial
Data: 1/12.01
20c. Location - City or Town, Stata: Olney,MD

21. Signature of Funaral Service Licensee: [signature]
22. Nama and Addrass of Facility: Pearson Funeral Home 472 N. Washington St.,Falls Church,VA 22046

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on each line. — Approximate Intarval Between Onset and Daath

Immedieta Causa (Final disaasa or condition rasulting in daath)
a. Cerebral Thrombosis — 1 WEEK
Dua to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaase or Injury that initiated evants rasulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in tha undarlying causa given in Part I.
HYPERTENSION
DIABETES MELLITUS TYPE 2

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to compliation of cause of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha cause(s) and mannar stated.
29b. Signatura and title of certifiar: [signature] (M.D.)
29c. Licensa number: D 18054
29d. Data signed (Month, Day, Year): JANUARY 11, 2001
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852

State Registrar

31. Data filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signatura: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00818

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DEBORAH L. PARKER
2. Date of Death Month / Day / Year: JAN 07 2001
3. Time of Death: 2:01 PM
4a. Facility Name *(If not institution, give street and number)*: HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 215-82-1090
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 37 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 6, 1963
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Burtonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13520 Greencastle Ridge Terrace, #102
10f. Zip Code: 20866
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Technical Support Specialist
16b. Kind of Business/Industry: Network Administrator

17. Father's Name *(First, Middle, Last)*: Nelson Cooper
18. Mother's Name *(First, Middle, Maiden Surname)*: Janet Garey Dorsey

19a. Informant's Name/Relationship *(Type, Print)*: Donald L. Parker - Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13520 Greencastle Ridge Terrace, #102, Burtonsville MD 20866

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Date: 1-11-01
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Robert E. Smith
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)
a. PNEUMONIA WITH RESPIRATORY FAILURE — 10 DAYS

Due to (or as a consequence of):
b. H.I.V. INFECTION — 7 years

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Due to (or es e consequence of):
c. SEPSIS — 10 DAYS

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- NEUROPATHY
- LOSS OF VISION due to RETINITIS
- ANEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Jerry E Seals MD
29c. License number: D25210
29d. Date signed *(Month, Day, Year)*: JAN/07/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JERRY SEALS, MD 3460 ELLICOTT CENTER DR. ELLICOTT CITY, MD.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00819

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Francis Parise

2. Date of Death (Month, Day, Year): January 9, 2001

3. Time of Death: 4:05 PM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 191-12-6928

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 13, 1923

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 12309 Treetop Drive, Apt. 21

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, give Yeer or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Furniture Salesman

16b. Kind of Business/Industry: Retail Department Store

17. Father's Name (First, Middle, Last): Frank Parise

18. Mother's Name (First, Middle, Meiden Surname): Teresa Vizza

19a. Informant's Name/Relationship (Type, Print): Jessie R. Parise / Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 12309 Treetop Dr., #21, Silver Spring, Maryland 20904

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Maryland Veteran's Cem.

Dete: 01/16/01

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funtral Service Licensee: Richard Spencer

22. Name end Address of Facility: Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert feilure. List *only one* cause on each line.

		Approximate Interval Between Onset and Deeth
Immediate Cause (Final disease or condition resulting in death)	a. RESPIRTORY FAILURE	2 WEEKS
Due to (or as a consequence of):	b. CONGESTIVE HEART FAILURE	YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	c. PULMONARY HYPERTENSION	YRS
Due to (or as a consequence of):	d. RHEUMATIC HEART DISEASE	DECADES

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, ATRIAL FIBRILLATION, RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐**Medical Examiner:** On tha basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Steven T. Kariya

29c. License number: D36252

29d. Date signed (Month, Day, Year): JANUARY 09, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): STEVEN T. KARIYA, MD 11501 GEORGIA AVE, # 515 WHEATON MD 20902

State Registrar

31. Dete filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 10

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00820

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA ANNE PEREGO
2. Date of Death (Month, Day, Year): JAN. 1, 2001
3. Time of Death: 4:30 AM
4a. Facility Name (If not institution, give street and number): 2717 LAWNDALE RD.
4b. City, Town, or Location of Death: FINKSBURG
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 218-58-3721
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/4/1950
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: FINKSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2717 LAWNDALE RD.
10f. Zip Code: 21048
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: HOME MAKER

17. Father's Name (First, Middle, Last): JOHN HOWARD MILLER
18. Mother's Name (First, Middle, Maiden Surname): VERA SCHREIBER

19a. Informant's Name/Relationship (Type, Print): HUSBAND FREDERICK T. PEREGO
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2717 LAWNDALE RD., FINKSBURG, MD. 21048

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY | Date: 1/4/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: ▶ Thomas D. Fletcher Jr.
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic carcinoma — 2½ mos.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None Known

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residance 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Howard Saint, M.D.
29c. License number: Md. # D15552
29d. Date signed (Month, Day, Year): 1/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard Saint, M.D. 555 S. Center St. Westminster, Md. 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 02 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 00821

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIAN BOWERS BUCKMAN POWELL
2. Date of Death Month: 1 Day: 2 Year: 2001
3. Time of Death: 0430
4a. Facility Name *(If not Institution, give street and number)*: Atlantic General Hospital
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 217-16-4200
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11/24/1921
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Ocean Pines
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11421 Manklin Cr. RD Bldg. A-3
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: William C. Buckman
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Elizabeth Bowers

19a. Informant's Name/Relationship *(Type, Print)*: Pam D'Amico/Granddaughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10 Whisper Lane Berlin, MD 21811

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cape Henlopen Crematory
Date: 1/3/01
20c. Location - City or Town, State: Frankford, DE

21. Signature of Funeral Service Licensee: W. Gill Burbage
22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 0430 1/2/01
Lillian Powell 217-16-4200
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Septic Shock	12°
Due to (or as a consequence of): b.	Peritonitis	24°
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Perforated duodenal ulcer	24°
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D0054997
29d. Date signed *(Month, Day, Year)*: 1/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Darnell, M.D. 9711 Healthway Dr. Berlin, MD 21811

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00822

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul Quattrone

2. Data of Death Month Day Year: January 8, 2001

3. Time of Death: 8:45 a.m.

4a. Facility Name *(If not institution, give street and number)*: 3010 Ellicott Road

4b. City, Town, or Location of Death: Beltsville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-20-6568

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 24, 1925

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3010 Ellicott Road

10f. Zip Code: 20705

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Proprietor

16b. Kind of Business/Industry: Dry Cleaning Business

17. Father's Name *(First, Middle, Last)*: Bruno Quattrone

18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Azzarella

19a. Informant's Name/Relationship *(Type, Print)*: Angelina Quattrone / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3010 Ellicott Road, Beltsville, Maryland 20705

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 01/11/01

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Richard Smith

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lymphoma — chronic

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Wallmark M.D

29c. License number: 53177

29d. Date signed *(Month, Day, Year)*: Jan 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Wallmark 9707 Medical Ctr. Dr. Rockville MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00823

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dey	Yeer	3. Time of Death
LESTER	J.	ROSER	JAN	3	2001	5:45 PM

4e Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NATIONAL NAVAL MEDICAL CENTER	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Deys	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
364-28-3236	1☒M 2☐F	76 Yrs.					Feb. 19, 1924	Michigan

Usual Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
600-A Veirs Mill Road	20852	United States

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐Never Merried 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Yeer or Detes: WW II	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	5+	Instructor	Air Traffic Control

17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Rudolph Cagala	Marie Agnetta

19e. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Erin C. Roser/Daughter	11657 Drum Castle Terrace, Germantown, MD 20876

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1☐Buriel 2☒Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)	Montgomery Crematorium, Inc.	January 12, 2001	Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ray Lee M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Intervel Between Onset end Deeth

Immediete Ceuse (Final disease or condition resulting in deeth)
e. HYPOXIA

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest
b.

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Wes en eutopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of death?
1☒Yes 2☐No	1☐Yes 2☒No

25. Wes cese referred to medicel examiner?	26. Plece of Deeth (Check only one)	
1☐Yes 2☒No	Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth	28e. Dete of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and manner es steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
Carolyn McMonigle MD	40812-020 (WI)	1/4/01

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)
C.E.MCMONIGLE, LT, MC, USN
NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600

State Registrar

31. Dete filed (Month, Day, Yeer)	32. Registrer's Signeture
JAN 12 2001	Laura G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 00824

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NORMA ROSENTHAL ROSENBLUM
2. Date of Death Month / Day / Year: JANUARY 4, 2001
3. Time of Death: 11:12 AM
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-46-8119
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 02-11-1924
9. Birthplace *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8811 COLESVILLE ROAD #401
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: CHARLES ROSENTHAL
18. Mother's Name *(First, Middle, Maiden Surname)*: BESSIE "UNAVAILABLE"

19a. Informant's Name/Relationship *(Type, Print)*: JACK ROSENBLUM/HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8811 COLESVILLE ROAD #401, SILVER SPRING, MD 20910

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING DAVID MEMORIAL GDNS
Date: JAN 05, 2001
20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. PNEUMONIA
Due to (or as a consequence of):
c. LUNG CANCER
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D21435
29d. Date signed *(Month, Day, Year)*: January 4, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. IRA PAUL KREFTING, 2101 MEDICAL PARK DR #100, SILVER SPRING, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. b

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00825

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SANDY ROBINSON
2. Date of Death (Month, Day, Year): JANUARY 02, 2001
3. Time of Death: 9:30 PM
4a. Facility Name (If not institution, give street and number): MARINER OF KENSINGTON
4b. City, Town, or Location of Death: KENSINGTON
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 080-03-6980
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): JULY 9, 1920
9. Birthplece (State or Foreign Country): VIRGINIA

Usual Residence of Decedant

10a. Stete: D.C.
10b. County: N/A
10c. City, Town or Location: WASHINGTON
10d. Insida City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 5901 EAST CAPITOL ST. S.E. #403
10f. Zip Coda: 20019
10g. Citizan of What Country?: UNITED STATES

11. Marital Stetus: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No — If Yas, Giva Yaar or Dates: Ukn
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: AFRO-AMERICAN

15. Decedant's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 7TH | College (1-4or 5+):
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): CONSTRUCTION
16b. Kind of Businass/Industry: PRIVATE

17. Fathar's Name (First, Middle, Last): TIMOTHY ROBINSON
18. Mother's Nama (First, Middle, Maidan Surnama): LULA BAKER ROBINSON

19a. Inlorment's Name/Relelionship (Type, Print): SHEILA L. GREENE/DAUGHTER
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 100 LEFFERTS AVE., BROOKLYN, N.Y. 11225

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cematary, crematory or othar placa): ROBINSON CEMETERY — Data: JAN.6,2001
20c. Location - City or Town, Stete: EMPORIA, VIRGINIA

21. Signature of Funeral Service Licensee: Edward M. Dudley
22. Nama and Addrass of Facility: DUDLEY FUNERAL HOME, 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complicetions that caused tha death. Do not antar tha mode of dying, such as cardiac or raspiretory arrast, shock, or haart failura. List only one cause on eech line. (Approximete Interval Between Onset and Death)

Immediata Causa (Finel disaasa or condition resulting in death): a. Prostate Cancer — 1 year
Dua to (or as a consequenca of):
Sequentially list conditions, if any, leading to immedieta cause. Entar Underlying Cause (Disaase or injury that initiated evants resulting in death) Last: b. Dua to (or as a consequanca of): c. Dua to (or as a consequance of): d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: dementia

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Were autopsy findings available prior to complation of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa referred to medical examinar? 1 [ ] Yes 2 [X] No
26. Placa of Daath (Chack only ona): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [X] Nursing Homa 5 [ ] Rasidanca 6 [ ] Other (Specify)
27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datermined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, date and place, and due to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to tha cause(s) and mannar stated.
29b. Signatura and title of certifier: MS
29c. License number: D0005752F
29d. Data signed (Month, Day, Year): January 8, 2001
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): D. Shmaltzlin, MS, 2309 Stonefield Road Carlsbad, MD 20905

State Registrar

31. Data filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signatura: Bruce B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00826

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dora Margaret Ricker
2. Date of Death (Month, Day, Year): January 7, 2001
3. Time of Death: 5:40 am
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-03-7257
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 21, 1902
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13107 Dumbarton Drive
10f. Zip Code: 20853
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sorter / Clerk
16b. Kind of Business/Industry: Engraving and Printing

17. Father's Name (First, Middle, Last): Ross Charles Alsop
18. Mother's Name (First, Middle, Maiden Surname): Cornelius McDonald

19a. Informant's Name/Reletionship (Type, Print): Barbara B. Ricker / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13107 Dumbarton Drive, Rockville, MD 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: Jan 10 2001
20c. Location - City or Town, State: Suitland , MD

21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Heart Failure	days
Due to (or as a consequence of): b.	Third Degree Heart Block	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D50678
29d. Date signed (Month, Day, Year): 1/7/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajeev Batra 10801 Lockwood Drive, Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00827

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary E. Richardson
2. Date of Death — Month: 1 Day: 9 Year: 2001
3. Time of Death: 11:10 PM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-20-3548
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 22, 1912
9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1704 Forest Glen Road
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): — College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper
16b. Kind of Business/Industry: D.C. Government

17. Father's Name *(First, Middle, Last)*: Edward Manigault
18. Mother's Name *(First, Middle, Maiden Surname)*: Julia Salley

19a. Informant's Name/Relationship *(Type, Print)*: Wilbur R. Jones Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 135 Presidents Dr., Durham, North Carolina 27704

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Cemetery — Date: 1-16-01
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Andre Thompson
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Pulmonary edema	24 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — b.	Acute renal failure	2 days
Due to (or as a consequence of):		
c.	Congestive heart failure	5 years
Due to (or as a consequence of):		
d.	Hypertension	>20 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elizabeth Winter MD
29c. License number: D0056087
29d. Date signed *(Month, Day, Year)*: 1/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elizabeth L. Winter MD 1500 Forest Glen Rd Silver Spring MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00828

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Earl Rhodes, Sr.

2. Date of Death — Month: January Day: 5, Year: 2001

3. Time of Death: 12:20 pm

4a. Facility Name *(If not institution, give street and number)*: 1110 Burketon Road

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-24-6342

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Dec. 2, 1924

9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1110 Burketon Road

10f. Zip Code: 20783

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator

16b. Kind of Business/Industry: Banking

17. Father's Name *(First, Middle, Last)*: Thomas Hillard Rhodes

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Marie Harley

19a. Informant's Name/Relationship *(Type, Print)*: Agnes D. Rhodes/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1110 Burketon Rd., Hyattsville, MD 20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 01/09/01

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Amyotrophic Lateral Sclerosis — 1.5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hubert J. Alpert, M.D.

29c. License number: D00143

29d. Date signed *(Month, Day, Year)*: 01/05/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hubert J. Alpert, M.D. 8630 Fenton st., Ste. 230, Silver Spring, MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 9 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00829

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles James Rhodes
2. Date of Death Month / Day / Year: January 6, 2001
3. Time of Death: 8:15 AM
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-32-5019
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 4,1928
9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Montgomery Village
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 18615 Walkers Choice Road, #5
10f. Zip Code: 20886
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Business Manager
16b. Kind of Business/Industry: Kitchen Supply

17. Father's Name *(First, Middle, Last)*: Emmett Rhodes
18. Mother's Name *(First, Middle, Meiden Surname)*: Grace Brachett

19a. Informant's Name/Relationship *(Type, Print)*: William R. Rhodes/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3500 Mobile Court, Davidsonville, MD. 21035

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: 1/10/01
20c. Location - City or Town, State: Silver Spring, MD.

21. Signature of Funeral Service Licensee: Michael A. Lubelsky
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. cerebrovascular accident — weeks

Due to (or as a consequence of):
b. bacterial endocarditis

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signeture end titie of certifier: Steven Dolinsky
29c. License number: 20148
29d. Date signed *(Month, Day, Year)*: January 7, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Steven Dolinsky 911 Russell Ave, Gaithersburg, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

GF

15+1

(10)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00830

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ursula C. Reburn
2. Date of Death (Month, Day, Year): Jan. 3, 2001
3. Time of Death: 11:05 PM.

4a. Facility Name (If not institution, give street and number): Glade Valley Nursing and Rehab
4b. City, Town, or Location of Death: Walkersville
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-12-7315
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 9, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Walkersville
10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 56 West Frederick Street
10f. Zip Code: 21793
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): John C. Keating
18. Mother's Name (First, Middle, Maiden Surname): Mary Winner

19a. Informant's Name/Relationship (Type, Print): Mary Matthews (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Deckman Court; Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Hill Memorial Park
Date: 1/6/01
20c. Location - City or Town, State: Lynchburg, VA

21. Signature of Funeral Service Licensee: Thomas E. Hornbaker
22. Name and Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 Wisconsin Ave., NW; Washington, DC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. AGING PROCESS

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. DEMENTIA (ALZHEIMERS).

Due to (or as a consequence of):
d. RENAL INSUFFICIENCY.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ABelani
29c. License number: D26137
29d. Date signed (Month, Day, Year): 1.9.01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anusha Belani, M.D. 198 Thomas Jefferson Dr. #104; Frederick, MD 20701-4317

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00831

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRIETT RAY

2. Date of Death: Month JAN Day 9th Year 2001

3. Time of Death: 0555 hrs

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 078-40-9954

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): 06/27/27

9. Birthplace (State or Foreign Country): Hemmingway, SC

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3593 Laurel View Court

10f. Zip Code: 20724

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker

16b. Kind of Business/Industry: County

17. Father's Name (First, Middle, Last): William Fillmore

18. Mother's Name (First, Middle, Maiden Surname): Annie Davis

19a. Informant's Name/Relationship (Type, Print): Joyce Ray Washington-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4905 Riding Ridge Ct. Laurel, MD 20707

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Lawn Cemetery

Date: 1/13/01

20c. Location - City or Town, State: Buffalo, NY

21. Signature of Funeral Service Licensee: Bernard O. Ames

22. Name and Address of Facility: Ames Funeral Home, Inc. 8914 Quarry Road, Manassas, Virginia 20110

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Cerebrovascular Accident — 5 days

Due to (or as a consequence of):
b. Cerebral arteriosclerosis — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes mellitus — years

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
End Stage renal disease
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D

29c. License number: D0052161

29d. Date signed (Month, Day, Year): 1.9.01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): NASIM ASHRAF, 7610 CARROLL AVE, #310, TAKOMA PARK, MD 20912

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0017-033
B.K.S

LEON T. REDD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00832

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEON T. REDD III

2. Date of Death Month Day Year: JAN. 1, 2001

3. Time of Death: 1836 PM

4a Facility Name *(If not institution, give street and number)*: OLD RITCHIE ROAD & WALKERMILL ROAD

4b. City, Town, or Location of Death: CAPITAL HEIGHTS

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-04-3633

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 20 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04/27/1980

9. Birthplace *(State or Foreign Country)*: WASHINGTON

Usual Residence of Decedent

10a. State: MD.

10b. County: P.G.

10c. City, Town or Location: BLADENSBURG

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4205 58th AVE. #A

10f. Zip Code: 20710

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: UNEMPLOYED

16b. Kind of Business/Industry: NONE

17. Father's Name *(First, Middle, Last)*: LEON T. REDD JR.

18. Mother's Name *(First, Middle, Maiden Surname)*: VALENCIA KING

19a. Informent's Name/Relationship *(Type, Print)*: VALENCIA KING REDD(MOTHER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1906 COUNTY RD. FORESTVILLE MD. 20747

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. OLIVET CEMETERY

Date: 1/8/01

20c. Location - City or Town, State: WASHINGTON D.C.

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: AUSTIN ROYSTER FUNERAL HOME 3821 14th ST. N.W. WASH. D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* AT SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: Found 1/1/01

28b. Time of Injury: 1825HRS

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Subject Shot

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: roadway

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Old Ritchie Road & Walker Mill Drive Capitol Heights Maryland

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Theodore M. Kiyonaga

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: JAN. 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 9 2001

32. Registrar's Signature: Emma G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

VOID

CERTIFICATE ⌘

01-00833

SEE

CERTIFICATE ⌘

00-136444

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00834

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Beatrice H. Randolph
2. Date of Death Month Day Year: January 8, 2001
3. Time of Death: 5:20 AM
4a. Facility Name *(If not institution, give street and number)*: Woodside Nursing Facility
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-46-3039
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 27, 1911
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9718 Woodland Drive
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Analyst
16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Richard Henderson
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Smith

19a. Informant's Name/Relationship *(Type, Print)*: Wanda W. Martin, daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8982 Wetbanks Court, Columbia, MD 21045

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory — Date: 1/13/01
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	2 days
Due to (or as a consequence of): b.	Decubiti ulcer	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D38262
29d. Date signed *(Month, Day, Year)*: Jan 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anurita Mendhiratta, M.D., 2401 Research Blvd, #340, Rockville, Md. 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00835

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VINCENT J. RAFFERTY

2. Date of Death (Month, Day, Year): JANUARY 9, 2001

3. Time of Death: 7:15PM

4a. Facility Name *(If not institution, give street and number)*: CARRIAGE HILL BETHESDA

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-26-3885

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 16, 1911

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: DC

10b. County: none

10c. City, Town or Location: Washington, DC

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 5103 Sherier Place, NW

10f. Zip Code: 20016

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Installer/Repairman

16b. Kind of Business/Industry: Telephone Company

17. Father's Name *(First, Middle, Last)*: Patrick Rafferty

18. Mother's Name *(First, Middle, Maiden Surname)*: Philomene Brittionere

19a. Informant's Name/Relationship *(Type, Print)*: Ellen Rafferty/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3934 Oak Street, Fairfax, Va. 22030

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Gate of Heaven Cemetery

Date: Jan. 12, 2001

20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: John F. DeVol

22. Name and Address of Facility: DeVol Funeral Home, 2222 Wisconsin Ave., NW., Washington, DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ISCHEMIC CARDIOMYOPATHY — 20 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE; PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marta Anne Schneider MD

29c. License number: D26331

29d. Data signed *(Month, Day, Year)*: 01/09/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARTA ANNE SCHNEIDER MD 5401 MACARTHUR BLVD NW WASH DC 20016

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00836

Amend #1, 1/11/2001, BMW, Montg. Co.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William ~~Hall~~ Hull Randolph
2. Date of Death: Month: January Day: 3 Year: 2001
3. Time of Death: 1:45 AM
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-34-5198
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 73 Yrs. If Under 1 Year: Months / Days If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 21, 1927
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 16321 S. Westland Drive
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1944/1945
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece · American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): College (1-4or 5+): 4
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Director of Office of Investigation/Security
16b. Kind of Business/Industry: Department of Commerce

17. Father's Name (First, Middle, Last): Lacy Sauver
18. Mother's Name (First, Middle, Maiden Surname): Mary Virginia Hortenstine

19a. Informant's Name/Relationship (Type, Print): Donna A. Randolph/Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 16321 S. Westland Dr., Gaithersburg, MD. 20877

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Parklawn Memorial Park
Date: 1/8/2001
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Robert J. DeVol
22. Name end Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in deeth)	a. Anoxi Encepholopathy	3 days
Due to (or as e consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Ventricular Fibrillation	3 days
Due to (or es a consequence of):		
	c. Coronary Artery Disease	10 years
Due to (or as e consequence of):		
	d.	

Part II. **Other signficant conditions** contributing to death but not resulting in the underlyng cause given in Part I.

Congestive Heart Failure

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carl I. Schoenberger MD.
29c. License number: D 26540
29d. Date signed (Month, Dey, Year): January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl I. Schoenberger, M.D., 16220 Frederick Road, Gaithersburg, MD. 20877

State Registrar

31. Date filed (Month, Dey, Year): JAN 05 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

GF

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00837

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM PIERCE ROGERS

2. Date of Death (Month, Day, Year): January 2, 2001

3. Time of Death: 10:00 PM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 125-03-5235

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 23, 1913

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7007 Glenbrook Road

10f. Zip Code: 20814

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Attorney at Law

16b. Kind of Business/Industry: Legal

17. Father's Name *(First, Middle, Last)*: Harrison A. Rogers

18. Mother's Name *(First, Middle, Maiden Surname)*: Myra Beswick

19a. Informant's Name/Relationship *(Type, Print)*: Dale Rogers Marshall (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 28 E. Main Street; Norton, Mass. 02766

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cem.

Date: 01/08/01

20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: ▶ Nancy A. Percentie

22. Name and Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 Wisconsin Ave., NW Washington, DC 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sie Kong MD for Dr IRVING MIZUS

29c. License number: D36456

29d. Date signed *(Month, Day, Year)*: JAN. 2nd, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sie K. ONG MD. 8600 Old Georgetown Rd. Bethesda MD 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

WILLIAM ROGERS JAN. 02, 2001. 10PM GF

30

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00838

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ISRAEL SUDAK
2. Date of Death (Month, Day, Year): JANUARY 9, 2001
3. Time of Death: 11:42 PM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 091-26-4724
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 1, 1916
9. Birthplace (State or Foreign Country): POLAND

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6121 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ELECTRICIAN
16b. Kind of Business/Industry: NY TRANSIT AUTH.

17. Father's Name (First, Middle, Last): GEORGE SUDAK
18. Mother's Name (First, Middle, Maiden Surname): GISIA SCHULAMN

19a. Informant's Name/Relationship (Type, Print): HAROLD SUDAK/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5201 RENWICK COURT, BURKE, VIRGINIA 22015

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEMORIAL GDNS
Date: JAN 12, 2001
20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	days
Due to (or as a consequence of):	b. Acute renal failure	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Urosepsis	days
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed (Month, Day, Year): January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Israel Sudak 1-9-01 11:42 p.m.

3

CPS
01-0049-031
SUSAN STOLOV
amend item 23a,27 per me G791 1/31/01 yf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00839

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Susan Linda Stolov
2. Date of Death (Month, Day, Year): January 3, 2001
3. Time of Death: 11:15 AM
4a. Facility Name (If not Institution, give street and number): 10250 Westlake Drive #801
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 104-32-9929
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 8, 1942
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10250 Westlake Drive #801
10f. Zip Code: 20817
10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): ; College (1-4or 5+): 3
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Martin Harris
18. Mother's Name (First, Middle, Meiden Sumame): Kay Horowitz

19a. Intormant's Name/Relationship (Type, Print): Debra S. Howley/Daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Buttermere Ct., Potomac, MD 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Jan. 5, 2001
20c. Location - City or Town, Slate: Alexandria, VA

21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert teilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yaa 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) scene

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examinetion end/or Investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner steted.

29b. Signature end title of certifier: Marjorie Mc Yell
29c. License number: OCME
29d. Dete signed (Month, Dey, Year): January 4, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): HARRY SHAPIRO M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year): JAN 0 8 2001
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

GF

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item #5,per FH,2/20,G792,gap

Certificate of Death

Reg. No. 2001 00840

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John David Stevens

2. Date of Death: Month January Day 10, Year 2001

3. Time of Death: 12:45 AM

4a. Facility Name (If not institution, give street and number): Carriage Hill Bethesda

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: ~~216-22-1100~~ ~~216 22 1188~~

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 29, 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8811 Victory Lane

10f. Zip Code: 20854

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): - College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Classification Supervisor

16b. Kind of Business/Industry: State of Maryland

17. Father's Name (First, Middle, Last): George Jackson Stevens, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Frances E. Craig

19a. Informant's Name/Relationship (Type, Print): Elizabeth S. Cross/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8811 Victory Lane, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: January 12, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 3-5 days

Due to (or as a consequence of):

b. Multi-infarct Dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c. Diabetes Mellitus, Type II — years

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dysphagia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D35579

29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan J. Miller, M.D. 6844 Tulip Hill Terrace, Bethesda, Maryland 20816

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2041

VOID

CERTIFICATE #

01-00841

SEE

CERTIFICATE #

00-43645

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00842

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean H. Stebbins

2. Data of Death — Month: Jan. Day: 5, Year: 2001

3. Time of Death: 5:54 AM

4a. Facility Name (If not institution, giva street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 445-20-1568

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 80 Yrs.

If Undar 1 Yeer — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth (Month, Day, Year): April 20, 1920

9. Birthplaca (Stata or Foraign Country): North Dakota

Usual Rasidence of Decedant

10a. Stata: Virginia

10b. County:

10c. City, Town or Location: Alexandria

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 4800 Fillmore Avenue #456

10f. Zip Coda: 22311

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Yaer or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedant's Education (Specify only highast grada completed) — Elementary/Secondary (0-12): Collega (1-4or 5+): 5+

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Division Director

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): William Clyde Stebbins

18. Mothar's Nama (First, Middle, Maiden Surnema): Harriet Helen Warren

19a. Informant's Name/Reletionship (Type, Print): William A. Wisner (nephew)

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 2714 Plyers Mill Raod Silver Spring, Maryland 20902

20a. Method of Disposition: 1☐ Burial 2☒ Crametion 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cemetary, cramatory or othar piece): Metropolitan Crematory

Data: Jan. 5, 2001

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funaral Sarvice Licensee: James E Oaks

22. Nema and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Entar tha disease, or complicetions that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one ceuse on each line.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disaase or condition resulting in deeth):

a. Acute Respiratory Failure — NEEKS

Dua to (or as a consequance of):

b. Interstitial Lung disease

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Dua to (or as a consequence of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Aortic Regurgitation, Delirium Pneumonia

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledga, daath occurred at tha time, data and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and piece, and dua to the cause(s) and manner stated.

29b. Signatura and titla of certifiar: Medical Examiner

29c. Licansa number: D42403

29d. Data signed (Month, Day, Year): 1-5-2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): RAJ MATHUR 106 IRVING street, NW Washington DC 20010

State Registrar

31. Data filed (Month, Day, Year): JAN 0 8 2001

32. Registrar's Signature: James G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00843

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Paul Spock
2. Date of Death (Month, Day, Year): January 3, 2001
3. Time of Death: 4:10 PM

4a. Facility Name (If not institution, give street and number): POtomac Valley Nursing Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 094-20-3673
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 15, 1927
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1235 Potomac Valley Drive
10f. Zip Code: 20850
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Officer
16b. Kind of Business/Industry: General Services Admin. U.S. Government

17. Father's Name (First, Middle, Last): Michael Spock
18. Mother's Name (First, Middle, Maiden Surname): Mary Spiak

19a. Informant's Name/Relationship (Type, Print): Mary E. Spock / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3221 Salemtoen Drive, Winston- Salem, NC 27106

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Transfiguration Cemetery — Date: 01/08/01
20c. Location - City or Town, State: Coal Township, PA

21. Signeture of Funeral Service Licensee: ▶ Alan J. Donnell
22. Name end Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

G.F.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Congestive heart failure

Due to (or as a consequence of):
c. Coronary arteriosclerosis

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular accident
Senile dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Walter E. Goozh, M.D.
29c. License number: D01120
29d. Date signed (Month, Day, Year): January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Walter E. Goozh, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00844

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Daniel Sorrell
2. Date of Death (Month, Day, Year): January 7, 2001
3. Time of Death: 2122
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-36-8044
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 23, 1940
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Wheaton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12513 Bushey Drive
10f. Zip Code: 20906
10g. Citizen of What Country?: Washington, D.C.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No
If Yes, Give Year or Dates: 1958-1962
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yas 2 [X] No Specify:
14. Rece - American Indien, Black, White, etc.
Specify: Caucasian

15. Decedant's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Prepress Scanner Operator
16b. Kind of Business/Industry: Printing

17. Father's Name (First, Middle, Last): Nelson Webster Sorrell
18. Mother's Name (First, Middle, Maiden Surname): Anna Cookman

19a. Informant's Name/Relationship (Type, Print): Marilyn Sorrell Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12513 Bushey Drive, Wheaton, Maryland 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): National Memorial Park
Date: 1/11/2001
20c. Location - City or Town, State: Fairfax, Virginia

21. Signature of Funeral Service Licensee: [signature] CFSP
22. Name and Address of Facility: Robert J. Murphy Funeral Home, Inc. 4510 Wilson Blvd. Arl.Va.22203

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — minutes

Due to (or as a consequence of): Hypertension — long standing

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] James DelVecchio, MD
29c. License number: D44521
29d. Date signed (Month, Day, Year): January 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James DelVecchio, MD Holy Cross Hospital 1500 Forest Glen Road Silver Spring, Maryland 20910

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00845

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen R. Smith

2. Date of Death (Month, Day, Year): January 7, 2001

3. Time of Death: 9:47 AM

4a. Facility Name *(If not institution, give street and number)*: Brighton Gardens

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-07-0328

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 13, 1907

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4707 Broad Brook Drive

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Buyer

16b. Kind of Business/Industry: Department Store

17. Father's Name *(First, Middle, Last)*: Cyrus Christian Rilee

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Pearl Walton

19a. Informant's Name/Relationship *(Type, Print)*: Nancy Lee Shetterly/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4707 Broad Brook Drive, Bethesda, Maryland 20814

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.

Date: January 8,2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Michael F. Higgins M00846

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisonsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 033357

29d. Date signed *(Month, Day, Year)*: 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee Saunders Mortician 5530 Wisconsin Ave Chevy Chase MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00846

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Ben	Edward	Smith	January	06	2001	5:45 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
VAMHCS FORT HOWARD DIVISION	FORT HOWARD	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
410-74-6238	1☒M 2☐F	54 Yrs.					07-12-46	Tennessee

Usual Residance of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Crofton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1863 Harcourt Avenue	21114	United States

11. Marital Stetus	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yas 2☐No If Yes, Give Yaar or Datas: 1971-1994	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Endodontist	Medical

17. Fathar's Name (First, Middle, Last)		18. Mother'e Name (First, Middle, Meiden Surneme)	
Woodrow	Smith	Reba	Church

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Mona Smith/Wife	1863 Harcourt Ave, Crofton, MD 2114

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stata
1☐Burial 2☐Cramation 3☐Removal from Stata 4☒Donetion 5☐Other (Specify)	Uniformed Services Univ.	1- 8-01	Bethesda, MD

21. Signature of Funarel Service Licensee: ▶ Kevin A Hoody

22. Name and Address of Facility: Rapp Funeral & Cremation Serv. Stephen D. Lohrmann, 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GLIOBLASTOMA MULTIFORME	7 months
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b.	
	Due to (or es a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yas 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Deeth	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ George E. Wicks III	D41365	January 6, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
GEORGE E. WICKS, M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052

State Registrar

31. Data filed (Month, Dey, Year)	32. Registrar's Signature
JAN 0 9 2001	▶ Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

SMITH, BEN E.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

40+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00847

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William R. Slattery, Sr.

2. Date of Death Month / Day / Year: January 10, 2001

3. Time of Death: 5:00 am

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-10-5863

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 10, 1919

9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: None

10b. County: None

10c. City, Town or Location: Washington, DC

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 7940 Orchid Street NW

10f. Zip Code: 20012

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Manager

16b. Kind of Business/Industry: Automotive

17. Father's Name *(First, Middle, Last)*: William John Slattery

18. Mother's Neme *(First, Middle, Maiden Sumame)*: Agnes Cecilia Scanlon

19a. Informant's Name/Relationship *(Type, Print)*: Margaret A. Slattery/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7940 Orchid Street NW, Washington, DC 20012

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: Jan 13 2001

20c. Location - City or Town, Steta: Alexandria, VA

21. Signature of Funeral Service Licensee: John E. Collins

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Severe ischaemic Cardiomyopathy

Due to (or as a consequence of): b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Sepsis

Due to (or as a consequence of): d. Diabetes mellitis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute myocardial infarction
Hypertension
Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings evaileble prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was casa referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Piece of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signatura end title of certifier: Geo Ellis MD

29c. Licansa number: D23170

29d. Date signed *(Month, Day, Year)*: JAN 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gita Bakshi MD 9406 Old Georgetown Rd Bethesda MD 20814

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Battimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00848

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert A. Silva
2. Date of Death (Month, Day, Year): January 8, 2001
3. Time of Death: 7:28 PM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 218-13-7613
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 30 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 11, 1970
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1420 Thornden Road
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Ski Repair Manager
16b. Kind of Business/Industry: Ski Resort

17. Father's Name (First, Middle, Last): Gaston F. Silva
18. Mother's Name (First, Middle, Maiden Surname): Judy F. Blackwell

19a. Informant's Name/Relationship (Type, Print): Gaston F. Silva/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1420 Thornden Road, Rockville, Maryland 20851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dillon Cemetery
Date: Jan. 15, 2001
20c. Location - City or Town, State: Dillon, Colorado

21. Signature of Funeral Service Licensee: [signature]
M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. Ewings SARCOMA	1 YEAR
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D35675
29d. Date signed (Month, Day, Year): JANUARY 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan 18111 Prince Philip Dr. OLNEY, MD 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00849

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jane A. Sholl
2. Date of Death Month Day Year: January 9, 2001
3. Time of Death: 12:50 pm
4a. Facility Name *(If not institution, give street and number)*: 7310 15th Avenue
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-07-1076
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 21, 1917
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7310 15th Avenue
10f. Zip Code: 20912
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Samuel Edwards
18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Allen

19a. Informant's Name/Relationship *(Type, Print)*: L. David Sholl, Jr. / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1086 Galway Road, Davidsonville, MD 21035

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Morrisville Methodist Church — Date: Jan 12 2001
20c. Location - City or Town, State: Morrisville, VA

21. Signature of Funeral Service Licensee: ▶ William T Byrd
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma Lung
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael Berard, MD
29c. License number: D 26287
29d. Date signed *(Month, Day, Year)*: January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Berard, MD 7305 Baltimore Ave., Suite 107, College Park , MD 20740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: ▶ Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00850

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Daniel H. G. Shim
2. Dete of Deeth Month / Dey / Yeer: January 6, 2001
3. Time of Deeth: 4:00 PM
4e Fecility Neme *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Locetion of Deeth: Olney
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 072-66-6215
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 20 Yrs.
If Under 1 Yeer: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Oct. 25, 1980
9. Birthplece *(State or Foreign Country)*: Washington, DC

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Locetion: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 14337 Long Green Drive
10f. Zip Code: 20906
10g. Citizen of Whet Country?: United States
11. Meritel Stetus: 1☒ Never Merried 2☐ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No — If Yes, Give Yeer or Detes: 1998 2001
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indien, Bieck, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Enlisted
16b. Kind of Business/Industry: U.S. Marines
17. Fether's Neme *(First, Middle, Last)*: Ray Shim
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Rosemarie Thomas
19e. Informent's Neme/Reletionship *(Type, Print)*: Rosemarie Thomas Mother
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 14337 Long Green Drive, Silver Spring, MD 20906
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Gate of Heaven Cemetery
Dete: 1/11/01
20c. Locetion - City or Town, Stete: Silver Spring, MD
21. Signeture of Funerel Service Licensee: Thomas J. Clyburn
22. Neme and Address of Fecility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line. — Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth): a. Asphyxiation
Due to (or es e consequence of):
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown
24e. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause ot death? 1☐ Yes 2☒ No
25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Deeth: 1☐ Neturel 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*: Jan. 6, 2001
28b. Time of Injury: 4:00 P.M.
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Hanging
28e. Ploce of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*: laundry room, home
28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*: 14337 Longgreen Drive Silver Spring, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end menner stated.
29b. Signeture end title of certifier: Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed *(Month, Day, Year)*: January 6, 2001
30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00851

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Harold Shelton

2. Date of Death (Month, Day, Year): January 4, 2001

3. Time of Death: 1:40am

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 296-07-5938

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 31, 1917

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 935 Beacon Square Court #16

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Metallurgical Engineer

16b. Kind of Business/Industry: Engineering

17. Father's Name *(First, Middle, Last)*: Charles F. Shelton

18. Mother's Name *(First, Middle, Maiden Surname)*: Daisy Trump

19a. Informant's Name/Relationship *(Type, Print)*: Phyllis Marjorie Shelton (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 935 Beacon Square Court #16, Gaithersburg, MD 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cramatory or othar place)*: Metropolitan Crematory

Date: 1/6/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert L. DeVol

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's, Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D21340

29d. Date signed *(Month, Day, Year)*: January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond Bass 3941 Ferrara Drive, Wheaton, MD 20906

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20 +1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00852

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Fannie Shapiro

2. Date of Death: Month January Day 4, Year 2001

3. Time of Death: 11:45A.

4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-07-3973

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 18, 1903

9. Birthplace (State or Foraign Country): Russia

Usuel Rasidenca of Dacedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6121 Montrose Road

10f. Zip Code: 20852

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Merriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent'a Eduestion (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson

16b. Kind of Business/Industry: retail

17. Father's Nema (First, Middla, Last): Kalmar Goldiner

18. Mother's Name (First, Middle, Maiden Sumema): Leah unk

19a. Informent's Name/Reletionship (Type, Print): Fay S. Rubin - Daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20814: 5225 Pooks Hill Rd., #420N. Bethesda, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Beth Shalom Cemetery

Date: 1/7/2001

20c. Location - City or Town, State: Capital Heights, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, auch es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onsat and Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)

a. ASPIRATION PNEUMONIA, BOTH LUNGS — 1 WEEK

Due to (or as a consequence of):

b. MULTI-INFARCT DEMENTIA

Sequentially list conditions, it any, leading to immediete ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Last

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was case referred to medical examinar? 1☐ Yas 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: [signature] M.D.

29c. Licensa number: D18084

29d. Date aigned (Month, Day, Year): JANUARY 04, 2001

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): D.D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852

State Registrar

31. Data filed (Month, Dey, Year): JAN 0 9 2001

32. Registrar's Signeture: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00853

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Robert Selthoffer
2. Date of Death (Month, Day, Year): January 9, 2001
3. Time of Death: 8:00 AM

4a. Facility Name *(If not institution, give street and number)*: 18410 Honeylocust Circle
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 190-14-7243
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 4, 1923
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1200 Oak Hill Place, Apt. 1D
10f. Zip Code: 21403
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Representative
16b. Kind of Business/Industry: Sporting Goods

17. Father's Name *(First, Middle, Last)*: Vincent Selthoffer
18. Mother's Name *(First, Middle, Maiden Surname)*: Roseala Ver

19a. Informant's Name/Relationship *(Type, Print)*: Lizanne Selthoffer/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18410 Honeylocust Cir. Gaithersburg, MD 20879

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. Date: January 11, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
Lung Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Daughter's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D53306
29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Curtis Harris, M.D., 600 Ridgely Avenue, #231, Annapolis, Maryland 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00854

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN GEORGE SCHMITZ

2. Data of Death — Month: JAN; Day: 10; Year: 2001

3. Time of Death: 1:35 PM

4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 395-24-3560

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Aug. 12, 1930

9. Birthplace *(State or Foraign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: Virginia

10b. County: Rappahannock Co.

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14 Firehouse Lane

10f. Zip Code: 22747

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '52-'57

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Congressman

16b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: Jacob J. Schmitz

18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie Frueh

19a. Informent's Name/Reletionship *(Type, Print)*: Mary E. Schmitz - Wife

19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14 Firehouse Lane- Washington, Virginia 22747

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Arlington Nat'l Cemetery

Date: Jan24,01

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Addrass of Facility: Murphy Funeral Home 4510 Wilson Blvd-Arlington, Va. 22203

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBROVASCULAR ACCIDENT

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Wes cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending Invastigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. Licansa number: 9701454-NC

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): J.V. LAWLER, LT,MC,USNR NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00855

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary L. Sawchenko
2. Date of Death Month / Day / Year: January 7 2001
3. Time of Death: 3:00 a.m.
4a. Facility Name *(If not institution, give street and number)*: 19105 North Pike Creek Place
4b. City, Town, or Location of Death: Montgomery Village
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 233-46-7599
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 17, 1931
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Montgomery Village
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19105 North Pike Creek Place
10f. Zip Code: 20886
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Sam Liberatore
18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Liberatore

19a. Informant's Name/Relationship *(Type, Print)*: Charles Sawchenko/ Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19105 North Pike Creek Place, Montgomery Village, MD 20886

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory | Date: January 8, 2001
20c. Location - City or Town, State: Alexandria , VA

21. Signature of Funeral Service Licensee: ▶ Tracy A. Stuve
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive Gaithersburg, MD 20877

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastasis
Due to (or as a consequence of):
b. Colon Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptace of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and ptaca, and due to the cause(s) and manner stated.
29b. Signeture and title of certifier: ▶ Karowiec MD
29c. License number: D0035859
29d. Date signed *(Month, Day, Year)*: January 8, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Leszek Karowiek, M.D., 501 North Frederick Avenue, Gaithersburg, MD 20877

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit article.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00856

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucille Burr Sanderson
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 1:15 P.M.
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 159-07-1614
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 14, 1913
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10216 Southmoor Drive
10f. Zip Code: 20901
10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager
16b. Kind of Business/Industry: Dental Office

17. Father's Name (First, Middle, Last): William Burr
18. Mother's Name (First, Middle, Maiden Surname): Violet Williams

19a. Informant's Name/Relationship (Type, Print): Richard B. Sanderson / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3800 North Lakeshore Drive, Chicago, Illinois 60613

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: January 6, 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: John E. Collins
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., West, Silver Spring, Maryland 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. RESPIRATORY FAILURE	5 DAYS
Due to (or as a consequence of):	b. PNEUMONIA	1 WK
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SUSPECTED BRONCHOGENIC CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven T. Kariya
29c. License number: D36252
29d. Date signed (Month, Day, Year): JANUARY 05, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): STEVEN T. KARIYA, MD 11501 GEORGIA AVE #515 WHEATON MD 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00857

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Fern Myrtle SPRINGER

2. Date of Death — Month: Jan. Day: 1 Year: 2001

3. Time of Death: 11:00 a.m.

4a. Facility Name *(If not institution, give street and number)*: Coffman Nursing Home

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 212-14-7751

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 25, 1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11 W. Baltimore Street

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Head Cook

16b. Kind of Business/Industry: Dietary Dept. Hospital

17. Father's Name *(First, Middle, Last)*: Joseph unknown Wibberley

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian unknown unknown

19a. Informant's Name/Relationship *(Type, Print)*: Victor J. Springer - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11810 Robinwood Drive Hagerstown, Md. 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rose Hill Cemetery — Date: 1/5/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dementia — 10 years

Due to (or as a consequence of):
b. Atherosclerosis Systemic Disease — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Samuel Chan, MD

29c. License number: D36655

29d. Date signed *(Month, Day, Year)*: JAN 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1185 MT AETNA RD. Hagerstown, MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 2001

32. Registrar's Signature: Donna B Hobbs

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME KNOWN TO PHYSICIAN-FERN MYRTLE SPRINGER

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00858

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Catherine SHUPING
2. Date of Death — Month: January Day: 1 Year: 2001
3. Time of Death: 7:00 AM
4a. Facility Name (If not institution, give street and number): Ravenwood Assisted Living
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-42-6173
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 3, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12906 Lauran Road
10f. Zip Code: 21742
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): social worker
16b. Kind of Business/Industry: state

17. Father's Name (First, Middle, Last): Theodore Percival Jenkins
18. Mother's Name (First, Middle, Maiden Surname): Lillian Elizabeth Perkins

19a. Informant's Name/Relationship (Type, Print): Catherine Melby - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18932 Orchard Terrace Road, Hagerstown, Md. 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery — Date: 1/3/01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c. CEREBRAL VASCULAR DISEASE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death: YEARS / YEARS / YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD
29c. License number: D22043
29d. Date signed (Month, Day, Year): 1/02/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 11110 MEDICAL CAMPUS RD HAGERSTOWN, MD.

State Registrar

31. Date filed (Month, Day, Year): JAN 03 2001
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00859

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MARGARET EVELYN SWOPE
2. Dete of Death — Month: January; Dey: 1; Year: 2001
3. Time of Death: 0554
4a. Facility Neme *(If not institution, give street end number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 220-16-3732
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 76 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: July 20, 1924
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 37 Manor Drive, Apt. A3
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bieck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 0
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Driver
16b. Kind of Business/Industry: Commission on Aging

17. Father's Neme *(First, Middle, Last)*: John W. Sanbower, Sr.
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Margaret Anna Shank

19e. Informent's Neme/Relationship *(Type, Print)*: Delbert S. Barkdoll/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 37 Manor Drive, Apt. A3, Hagerstown, MD 21742

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Rose Hill Cemetery
Dete: Jan. 3
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signeture of Funerel Service Licensee: Kelly A. Zimmerman
22. Neme end Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)
a. RIGHT VENTRICULAR MYOCARDIAL INFARCTION — ONE WEEK

Due to (or as a consequence of):
b. COR PULMONALE

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last

Due to (or es e consequence of):
c. SMOKING

Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of exemineticn and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and Title of certifier: MD
29c. License number: 040622
29d. Dete signed *(Month, Dey, Yeer)*: January 2, 2001

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): BRADLEY HOFFMAN - MD 19236 MORNING VIEW DR HAGERSTOWN MD

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 03 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Swope, Margaret, Evelyn

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 00860

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VICTORIA FRANCINE SMITH
2. Date of Death (Month, Day, Year): JANUARY 2, 2001
3. Time of Death: 0635 AM
4e. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214- 70-2843
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 44 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec.26.1956
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1135 Arcola Avenue
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes ☒☐ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Never Worked (Disabled)
16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: John W.Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Frances J. Presbury

19a. Informant's Name/Relationship *(Type, Print)*: Frances J. Smith (Mother)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13920 Castle Blvd., Silver Spring, MD 20904

20e. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ash Memorial Cem.
Date: 1/8/01
20c. Location - City or Town, State: Sandy Spring, MD

21. Signature of Funeral Service Licensee: Sonja K. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. — Approximate Intarval Batween Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)
a. Cardiac Arrest
Due to (or as a consequenca of):
b. Metabolic Acidosis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or es e consequence of):
c. Chronic Renal Failure
Due to (or as e consequence of):
d. Sickle Cell Disease with crisis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hepatitis C., Hemosideorosis

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: ☒ 1 Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D20678
29d. Date signed *(Month, Day, Year)*: Jan. 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edwarda M. Buda, M.D. 1500 Forst Glen Rd., Silver Spring, MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00861

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jesse Shlemon
2. Data of Death: Month Jan. Day 4, Year 2001
3. Time of Death: 11:05 p.m.
4a. Facility Name *(If not institution, give street and number)*: Collingswood Nursing and Rehabilitation Ctr.
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 107-05-9813
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Jan. 14, 1909
9. Birthplace *(State or Foreign Country)*: Iraq

Usual Residance of Dacedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 299 Hurley Avenue
10f. Zip Coda: 20850
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Navar Marriad 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No — If Yas, Giva Yaar or Detas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Race - American Indian, Bleck, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada compiatad)*: Elementary/Secondary (0-12): 12 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Cook
16b. Kind of Businass/Industry: Restaurant

17. Father's Nama *(First, Middle, Last)*: (Unknown)
18. Mother's Nama *(First, Middle, Maidan Sumama)*: (Unknown)

19a. Informant's Name/Raiationship *(Type, Print)*: Sherry Seal/ Legal Guardian
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 401 Hungarford Dr., Rockville, MD. 20850

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Placa of Disposition *(Nama of camatery, cramatory or other piece)*: Chesapeake Crematory Inc. — Data: 1/6/01
20c. Location - City or Town, Stata: Beltsville, Md.

21. Signatura of Funaral Service Licensee: Kevin a Sharby
22. Nama and Address of Facility: Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, Md. 20910

G.F

Physician /Medical Examiner

23e. Part I. Entar the disaasa, or complications that causad tha daath. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on each lina.

		Approximata Interval Between Onsat and Death
Immediata Causa (Final disaasa or condition rasulting in daath) a.	Alzheimer's Dementia	10 years
Due to (or as a consequanca of): b.		
Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in death) Last — Due to (or as a consequance of): c.		
Due to (or as a consequance of): d.		

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: Pulmonary Embolus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings availeble prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa rafarrad to madical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Homa 5 [ ] Rasidanca 8 [ ] Othar *(Specify)*

27. Manner of Daath: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28e. Data of Injury *(Month, Day Yaar)* | 28b. Tima of Injury | 28c. Injury at Work? 1 [ ] Yas 2 [ ] No | 28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)* | 28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to tha causa(s) and mannar stated.

29b. Signatura and title of certifiar: Coulter
29c. Licansa number: D39934
29d. Data signed *(Month, Day, Year)*: January 5, 2001

30. Nama and address of person who complatad causa of daath (Item 23a) (Type, Print): STEVEN T. COULTER, MD 15201 Shady Grove Road, #202, Rockville MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001
32. Registrar's Signature: Jennie B. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

2

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00862

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hazel Raley Sadler
2. Date of Death Month Day Year: January 1, 2001
3. Time of Death: 1:50 PM
4a. Facility Name *(If not institution, give street and number)*: 4502 Dresden Street
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-10-7148
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jun 7, 1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4502 Dresden Street
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Alvah A. Raley
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret M. Henderson

19a. Informant's Name/Relationship *(Type, Print)*: J. Michael Sadler/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2242 Casemont Drive, Falls Church, VA 22046

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: Jan. 6, 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Robert D. Dyson
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure — 1 day

Due to (or as a consequence of):
b. Atrial Fibrillation — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hypertension — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patricia D. Kellogg MD
29c. License number: D21392
29d. Date signed *(Month, Day, Year)*: 01/02/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia D. Kellogg 809 Veirs Mill Rd, Rockville, MD 20851

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00863

Physician /Medical Examiner

1. Decedent's Nema *(First, Middla, Last)*: Margaret Catherine Spiegel

2. Dete of Death Month: January Day: 2, Year: 2001

3. Time of Death: 3:30 AM

4a. Facility Name *(If not institution, give street end number)*: Collingswood Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 573-46-7888

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 91 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Yaer)*: Sept. 1,1909

9. Birthplace *(Stete or Foreign Country)*: South Dakota

To Be Completed by Funeral Director

Usual Residance of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 16440 Tomahawk Drive

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest greda completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Nama *(First, Middla, Last)*: Charles Puetz

18. Mother's Name *(First, Middle, Meiden Surneme)*: Agnes Erpinbach

19a. Informent's Name/Relationship *(Type, Print)*: Margie Robertson (Daughter)

19b. Mailing Address *(Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code)*: 16440 Tomahawk Dr.- Gaithersburg, MD. 20878

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Byrd Cemetery

Dete: Jan. 5, 2001

20c. Location - City or Town, State: Timmonsville, SC

21. Signature of Funaral Service Licensee: ▶ Curtis E. Day

22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Drive - Gaithersburg, MD.20877

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseesa, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart tailure. List only one cause on each line.

Approximete Interval Between Onsat and Death

Immediate Ceuse (Final diseese or condition resulting in daath) e. Alzheimers — Years

Due to (or es a consequence of):

Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ Patricia L. Tomsko, MD

29c. License number: D51916

29d. Deta signed *(Month, Dey, Year)*: 1/2/2001

30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Dr. Patricia L. Tomsko M.D. 11140 Rockville Pike #348 Rockville, Md. 20852

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 05 2001

32. Registrer's Signeture: Debra B. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00864

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Brooks David Spencer
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 8:47 PM
4a. Facility Name (If not institution, give street and number): 509 N. Academy Street
4b. City, Town, or Location of Death: Greensboro
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 219-15-2031
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 16 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 9, 1984
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Greensboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 509 N. Academy Street
10f. Zip Code: 21639
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): student
16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): David A. Spencer
18. Mother's Name (First, Middle, Maiden Surname): Cathy Lynn Calloway Spencer

19a. Informant's Name/Relationship (Type, Print): David A. Spencer/ father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 N. Academy St. Greensboro, MD 21639

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greensboro Cemetery | Date: 1/8
20c. Location - City or Town, State: Greensboro, Maryland

21. Signature of Funeral Servica Licensee: ▶ Steven C Helfenbein
22. Name and Address of Facility: Fleegle & Helfenbein Funeral Home, P.A. P.O. Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic osteosarcoma — 16 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Couid not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David H Smith
29c. License number: D39887
29d. Date signed (Month, Day, Year): 1/08/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David H. Smith MD 29466 Pintail Drive Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 9 2001
32. Registrar's Signature: ▶ Renee G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00865

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harriett Maxine Tustian
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 1:45 AM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: None
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 25, 1909
9. Birthplace *(State or Foreign Country)*: Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9408 Seddon Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Eli Wilson Kidd
18. Mother's Name *(First, Middle, Maiden Surnama)*: Harriett Amelia Honora Muirhead

19a. Informant's Name/Reletionship *(Type, Print)*: Richard E. Tustian/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9408 Seddon Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Montgomery Crematorium, Inc.
Date: January 7, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M. M. E. Hogan M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GF

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure

Due to (or as a consequence of):
b. Atherosclerotic cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Acute renal failure

Due to (or as a consequence of):
d. Diabetes

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hip fracture

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: Dec. 29, 2000
28b. Time of Injury: 1215 A.M.
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Fall
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: home, hallway
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 9408 Seddon Rd., Bethesda, MD 20817

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

HARRIET TUSTIAN JAN. 5, 2001 0145

10

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed *(Month, Day, Year)*: January 5, 2001
30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00866

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FEHRA M. TOBIN
2. Data of Death (Month Day Year): January 8, 2001
3. Time of Death: 12:30 AM
4a Facility Name (If not institution, give street and number): Carriage Hill Nursing Center
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 014-22-2558
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Yaer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Aug. 15, 1912
9. Birthplace (State or Foraign Country): Ohio

Usual Residence of Decedent

10a. Stata: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5215 W. Cedar Lane
10f. Zip Code: 20814
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fether's Name (First, Middle, Last): Raymond Thom
18. Mothar's Nama (First, Middla, Meiden Surnama): Lena Roller

19a. Informant's Name/Ralationship (Type, Print): Donald W. Tobin - Son
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 6012 Talford Court Springfield, VA 22152

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetary, crematory or other place): Gate of Heaven Cemetery
Dete: 1/11/01
20c. Location - City or Town, Stete: Silver Spring, MD

21. Signature of Funerel Service Licensee: Thomas E. Hounbaker
22. Nama and Address of Facility: Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D. C. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immedieta Cause (Final disease or condition resulting in death)
a. Bacterial Pneumonia — 3 Days

Due to (or es a consequence of):
b. Chronic Obstructive Pulmonary Disease — Years

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Rheumatoid Arthritis
Atrial Fibrilation

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Wera eutopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa refarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, deta and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan Miller MD
29c. License number: D 35579
29d. Data signed (Month, Day, Year): January 8, 2001

30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print): Susan J. Miller, M.D. 6844 Tulip Hill Terrace Bethesda , MD 20816

State Registrar

31. Data filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00867

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth E. Tesh

2. Date of Death (Month, Day, Year): January 4, 2001

3. Time of Death: 5:29 PM

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 190-07-5660

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 3, 1910

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Pennsylvania | 10b. County: Scott Twnshp | 10c. City, Town or Location: Pittsburgh | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 2120 Greentree Rd, #808E | 10f. Zip Code: 15220 | 10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Joseph H. Huber

18. Mother's Name (First, Middle, Meiden Sumeme): Alice Laubenheimer

19a. Informent's Neme/Relationship (Type, Print): Patricia Liberati/Daughter

19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2120 Greentree Rd, #806E, Pittsburgh, PA 15220

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Queen of Heaven Cemetery | Date: Jan 8

20c. Location - City or Town, State: Bridgeville, PA

21. Signature of Funeral Service Licensee: Adam J. Darnell

22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. Enl only one cause on eech line.

		Approximete Interval Between Onset and Deeth
Immediate Ceuse (Final disease or condition resulting in death) a.	HEMOPHILUS INFLUENZA SEPSIS	6 DAYS
Due to (or es e consequence of):	PNEUMONIA	6 DAYS
Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last b.		
Due to (or es e consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, In my opinion, death occurred at the time, dete end place, and due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: John J. Myr. MD

29c. License number: 023630

29d. Date signed (Month, Day, Year): January 04, 2001

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Frank J. MAYO, MD 16226 Frederick Rd #213, Gaithersburg, MD 20877

State Registrar

31. Date filed (Month, Dey, Year): JAN 08 2001

32. Registrer's Signeture: Brenda B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00868

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris Lorraine Teague

2. Date of Death (Month, Day, Year): January 8 2001

3. Time of Death: 3:05 pm

4a. Facility Name *(If not institution, give street and number)*: Ivy Hall Nursing Home

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-07-1031

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 15, 1920

9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1300 Windlass Drive

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Matron

16b. Kind of Business/Industry: Corrections

17. Father's Name *(First, Middle, Last)*: Leslie B. Linaberg

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Hiawatha Penner

19a. Informant's Name/Relationship *(Type, Print)*: Lorrie L. Jachelski - granddaughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 511 Wilgis Road, Fallston, MD 21047

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Chesapeake Crematory | Date: 1/10/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: M00986

22. Name and Address of Facility: CAFA, Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive, Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Renal insufficiency

Due to (or as a consequence of):
c. Hypertension

Due to (or as a consequence of):
d. Aneurysm

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Degenerative Joint Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D31464

29d. Date signed *(Month, Day, Year)*: 1/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHOAIB A. HASHMI, 821 N. Entaw St Suite 308 Balt MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Linda G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00869

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary M. Tait
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 9:15 A.M.
4a. Facility Name *(If not institution, give street and number)*: Manor Care
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 031-03-8887
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 12, 1913
9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: none
10b. County: none
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4201 Butterworth Place, N.W. #226
10f. Zip Code: 20016
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Central Intelligence Agency
16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Andrew Malone
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Killelea

19a. Informant's Name/Relationship *(Type, Print)*: Lawrence D. Tait / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1349 Locust Road, N.W. Washington, D.C. 20012

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Ann's Cemetery
Date: Jan. 9, 2001
20c. Location - City or Town, State: Lenox, Mass.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave.,NW.,Washington,DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Stroke — hours

Due to (or as a consequence of):
b. Hypertension — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D 39456
29d. Date signed *(Month, Day, Year)*: January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lila T. McConnell,M.D., 5530 Wisconsin Ave.,#930, Chevy Chase, Md. 20815

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00870

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary C. Trout

2. Date of Death: Month January Day 1, Year 2001

3. Time of Death: 9:15 A.M.

4a. Facility Name (If not institution, give street and number): 2100 Wayside Drive Unit 1-A

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-16-0700

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 6, 1923

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2100 Wayside Drive Unit 1-A

10f. Zip Code: 21702

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Ft. Detrick/ Military

17. Father's Name (First, Middle, Last): Otis C. Whitmore

18. Mother's Name (First, Middle, Maiden Surname): Carmen E. Smith

19a. Informant's Name/Relationship (Type, Print): Carmen L. Martin, sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Maryland Avenue Walkersville, Maryland 21793

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory

Date: 1/2/2001

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Kenny R. Stauffer

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Colon cancer — 0 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 27109

29d. Date signed (Month, Day, Year): 1/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 1475 Fahrney Ave. Frederick MD 21702

State Registrar

31. Date filed (Month, Day, Year): JAN 03 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00871

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Klovia McKennon Tilley
2. Date of Death Month Day Year: January 2, 2001
3. Time of Death: 2:35AM
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Nursing Center
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-28-6055
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 1,1921
9. Birthplace *(State or Foreign Country)*: Arkansas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12844 Huntsman Way
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): – / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Speech Pathologist
16b. Kind of Business/Industry: Teaching

17. Father's Name *(First, Middle, Last)*: Rogers McKennon
18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Emison

19a. Informant's Name/Relationship *(Type, Print)*: William Reeves Tilley/ Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12844 Huntsman Way, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.
Date: January 3, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service License: M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer's Disease	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Urinary Tract Infection	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D0054566
29d. Date signed *(Month, Day, Year)*: January 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ravi Passi, M.D. 8609 Second Avenue, #404B, Silver Spring, MD 20910-3360

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GF

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00872

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NUNZIATA TILLEY

2. Data of Death — Month: JAN; Day: 2; Year: 2001

3. Time of Death: 9:23 P.M.

4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 576-31-1724

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 45 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Year)*: OCT. 31, 1955

9. Birthplace *(State or Foreign Country)*: ITALY

Usual Residence of Decedent

10a. State: VA.

10b. County: FAIRFAX

10c. City, Town or Location: LORTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7578 ASPEN PARK ROAD

10f. Zip Code: 22079

10g. Citizen of What Country?: ITALY

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: SALVATORE VARCHETTA

18. Mother's Name *(First, Middle, Maiden Surname)*: SILVESTRA FINANNO

19a. Informant's Name/Relationship *(Type, Print)*: EARL ROBERT TILLEY/HUSBAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7578 ASPEN PARK ROAD, LORTON, VA. 22079

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METROPOLITAN CREMATORY — Date: JAN. 3, 2001

20c. Location - City or Town, State: ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee: John F. DeVol

22. Name and Address of Facility: DEVOL FUNERAL HOME, 2222 WISC. AVE., N.W. WASH. D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Bassett

29c. License number: VA 0101840557

29d. Date signed *(Month, Day, Year)*: Jan 03 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN BASSETT, LT, MC, USN — NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20889-5600

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00873

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Tuneff
2. Date of Death Month Day Year: January 2 2001
3. Time of Death: 7:05 PM
4a. Facility Name *(If not institution, give street and number)*: Talbot County Hospice House
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 222-16-0345
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 23, 1912
9. Birthplace *(State or Foreign Country)*: Rhode Island

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Henderson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16545 Henderson Road
10f. Zip Code: 21640
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 HS Grad. | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Time Keeper
16b. Kind of Business/Industry: Manufacturing Company

17. Father's Name *(First, Middle, Last)*: Wasel Gniecko
18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine Pondo

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Bratten Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29471 Stoney Ridge Circle, Easton, Maryland 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Denton Cemetery | Date: 1/6/01
20c. Location - City or Town, State: Denton, Maryland

21. Signature of Funeral Service Licensee: Richard P. Moore
22. Name and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. gastric carcinoma — weeks
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice House

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Wafik Zaki M.D.
29c. License number: D0047534
29d. Date signed *(Month, Day, Year)*: 1/03/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wafik Zaki, M.D., 920 Market Street, Denton, Maryland 21629

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 4 2001
32. Registrar's Signature: Barbara A. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00874

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JEAN E. ULRICH
2. Date of Death (Month, Day, Year): JANUARY 4, 2001
3. Time of Death: 11:59 AM
4a. Facility Name *(If not institution, give street and number)*: Our Place
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 145-30-6731
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 13, 1913
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3124 Plyers Mill Road
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Philip Christian Weber
18. Mother's Name *(First, Middle, Maiden Surname)*: Susan E. Mortland

19a. Informant's Name/Relationship *(Type, Print)*: Elizabeth U. King/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3124 Plyers Mill Rd., Kensington, MD 20895

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 1/5/01
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: John L Chapis
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Renal Carcinoma	2 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D37975
29d. Date signed *(Month, Day, Year)*: January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey P. Indrisano 10801 Lockwood Dr. Suite #280, Silver Spring, MD 20901

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

GF

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00875

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cecile Vibert

2. Date of Death Month Dey Year: January 4,2001

3. Time of Death: 10:45 AM

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 262-66-2809

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug.30,1919

9. Birthplace *(State or Foreign Country)*: Canada

Usual Residence of Decedent

10a. State: DC

10b. County: none

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2515 K St.,NW #505

10f. Zip Code: 20037-2015

10g. Citizen of What Country?: USA/Canada

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondery (0-12): — College (1-4or 5+): 2

16a. Decedent's Usuat Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Garfinckel's Dep't.Store

17. Father's Name *(First, Middle, Last)*: Richard St.Amand

18. Mother's Name *(First, Middle, Maiden Surneme)*: Yvonne Couet

19a. Informent's Neme/Relationship *(Type, Print)*: Lucien St.Amand/Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 200 Rideau Terrace,#1005, Ottawa,Canada K1M-0Z3

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Beechwood Cemetery — Dete: Jan.12, 2001

20c. Location - City or Town, Stata: Ottawa, Canada

21. Signature of Funeral Service Licensee: James E. DeVol

22. Name and Address of Facility: DeVol Funeral Home, 2222 Wisconsin Ave.,NW.,Washington,DC 20007

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in death) a.	Sepsis	3 days
Due to (or as a consequence of):		
b.	Pneumonia	3 days
Due to (or es a consequence of):		
Sequentially list conditions, if any, leading to immediete causa. Entar Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last c.	Acute myocardial infarction	3 days
Due to (or es a consequence of):		
d.	Acute Renal failure	2 days

Part tt. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es steted. 2☐ **Medicat Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signature and titla of certifiar: Anurita Mendhiratta

29c. License number: D38262

29d. Date signed *(Month, Day, Year)*: January 6,2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Anurita Mendhiratta, MD., 2401 Research Blvd., Suite 340, Rockville, Md. 20850

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 0 9 2001

32. Registrar's Signeture: Irene B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00876

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRY VAL

2. Date of Death Month Day Year: JANUARY 2, 2001

3. Time of Death: 1:25A.M

4a. Facility Name *(If not institution, give street and number)*: SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579--14--6462

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 7, 1914

9. Birthplace *(State or Foreign Country)*: WASHINGTON D C

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6050 CALIFORNIA CIRCLE, # 403

10f. Zip Code: 20850

10g. Citizen of What Country?: U. S. A.

11. Meritel Status: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Dates: WW2 ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2 YEARS

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COMPTROLLER

16b. Kind of Business/Industry: NATIONAL WILDLIFE FEDERATION

17. Father's Name *(First, Middle, Last)*: SAMUEL VAL

18. Mother's Name *(First, Middle, Meiden Surname)*: ROSE TASH

19a. Informant's Name/Relationship *(Type, Print)*: MINA VAL -- WIFE

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 6050 CALIFORNIA CIRCLE, # 403, ROCKVILLE, MD. 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: MOUNT LEBANON CEMETERY

Dete: 1/3/2001

20c. Location - City or Town, State: ADELPHI, MARYLAND

21. Signeture of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name end Address of Facility: DANZANSKY--GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CONGESTIVE HEART FAILURE — YEARS

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. MITRAL REGURGITATION — YEARS

Due to (or as a consequence of):
d. RENAL FAILURE — DAYS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Yuri A. Deychak

29c. License number: D41311

29d. Date signed *(Month, Dey, Year)*: JANUARY 2. 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Yuri A. Deychak, M.D. 6410 Rockledge Drive, # 200, Bethesda, Maryland 20817--1809

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 04 2001

32. Registrar's Signature: ▶ Steven G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Harry Val - 12-01-0135

b

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00877

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY F. WRIGHT
2. Date of Death — Month: JANUARY; Day: 9; Year: 2001
3. Time of Death: 1230
4e. Facility Name *(If not institution, give street and number)*: 101 ODENHALL AVE #1007
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 245-36-8325
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: Nov. 26 1925
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10e. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 101 Odendhal Avenue Unit 1007
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12):
College (1-4or 5+): 3
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Edward D. Trogdon
18. Mother's Name *(First, Middle, Maiden Surname)*: LaLa Barfield

19e. Informant's Name/Relationship *(Type, Print)*: Pam Conti/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2717 Brigadier Blvd, Odenton, MD 21113

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mountain Rest Cemetery
Date: January 13, 2001
20c. Location - City or Town, State: Kings Mountain, N.C.

21. Signature of Funeral Service Licensee: TRACY A. STUMP
22. Name and Address of Facility: DeVol Funeral Home, 10 east Deer Park Drive Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEPRESSIVE DISORDER (BIPOLAR)

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD (ONE)
29c. License number: 015236
29d. Date signed *(Month, Day, Year)*: JANUARY 09, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CARL I. MARCUS, M.D. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00878

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Wallace Wimmer

2. Date of Death Month / Day / Year: January 6, 2001

3. Time of Death: 12:55PM

4a. Facility Name *(If not institution, give street and number)*: Montgomery Village Care and Rehab.

4b. City, Town, or Location of Death: Montgomery Village

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 163-03-4424

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 23, 1911

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10019 Vanderbilt Circle #12

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator

16b. Kind of Business/Industry: Retirement Community

17. Father's Name *(First, Middle, Last)*: Charles Wimmer

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha (not available)

19a. Informant's Name/Relationship *(Type, Print)*: Matthew E. Turpin/Grandson

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10019 Vanderbilt Circle #12, Rockville, Maryland 20850

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.

Date: January 9, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: MO1126

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia — weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. chronic gastroesophageal reflux

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia

malnutrition

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 20148

29d. Date signed *(Month, Day, Year)*: January 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Dulinsky MD 911 Russell Ave, Gaithersburg Md.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00879

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert W. Williams, Sr.

2. Date of Death Month Day Year: January 11, 2001

3. Time of Death: 5:43 AM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-07-7733

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 4, 1916

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 19224 Circle Gate Drive, #203

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): - ; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Real Estate

17. Father's Name *(First, Middle, Last)*: Joseph E. Williams

18. Mother's Name *(First, Middle, Maiden Surname)*: Monica Smith

19a. Informant's Name/Relationship *(Type, Print)*: Evelyn P. Williams/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19224 Circle Gate Drive, #203, Germantown, MD 20874

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.

Date: January 12, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	VENTRICULAR TACHYCARDIA	9 DAYS
Due to (or as a consequence of): b.	CORONARY ARTERY DISEASE	10 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	ISCHEMIC CARDIOMYOPATHY	10 YEARS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Virginia Colliver MD

29c. License number: 54597

29d. Date signed *(Month, Day, Year)*: JANUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIRGINIA COLLIVER 6410 ROCKLEDGE DR #200 BETHESDA MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Williams, Robert 1-11-01 5:43 A

12+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00880

Physician - /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES CHENG WEI
2. Date of Death — Month: JANUARY Day: 05 Year: 2001
3. Time of Death: 1825
4a. Facility Name *(If not institution, give street and number)*: SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 054-40-1647
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 20, 1932
9. Birthplace *(State or Foreign Country)*: China

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4801 Hornbeam Drive
10f. Zip Code: 20853
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Entrepreneur
16b. Kind of Business/Industry: International Trade

17. Father's Name *(First, Middle, Last)*: not available
18. Mother's Name *(First, Middle, Maiden Surname)*: not available

19a. Informant's Name/Relationship *(Type, Print)*: Katy Chiu Wei/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4801 Hornbeam Drive, Rockville, Maryland 20853

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: January 13, 2001
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: [signature] M01126
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE ORGAN FAILURE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. ANOXIC ENCEPHALOPATHY
Due to (or as a consequence of):
c. CLOSED HEAD INJURY
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)* — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*: DECEMBER 22 2000
28b. Time of Injury: 1549
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: DROVE HEAD-ON INTO TREE.
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: LOCAL STREET
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 4500 BLOCK-HORNBEAM DRIVE, ROCKVILLE, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] (OME)
29c. License number: D15236
29d. Date signed *(Month, Day, Year)*: JANUARY 7, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS, MD. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: [signature] B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

VOID

CERTIFICATE #

01-00881

SEE

CERTIFICATE #

00-43551

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #18, 1/9/2001, BMW, Montg.Co.

Certificate of Death

Reg. No. 2001 00882

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BASIL W. WATERS, JR.

2. Date of Death (Month, Day, Year): JANUARY 7, 2001

3. Time of Death: 6:15 PM

4a. Facility Name (If not institution, give street and number): FRIENDS NURSING HOME

4b. City, Town, or Location of Death: SANDY SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220 34 7764

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 30, 1907

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: DERWOOD

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 18103 MUNCASTER ROAD

10f. Zip Code: 20855

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FARMER

16b. Kind of Business/Industry: FARM

17. Father's Name (First, Middle, Last): BASIL W. WATERS, SR.

18. Mother's Name (First, Middle, Maiden Surname): JULIA BRADLEY MAGRUDER

19a. Informant's Name/Relationship (Type, Print): LAURA ANN WHIRLEY, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18017 MUNCASTER ROAD, DERWOOD, MD. 20855

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ST. JOHN'S CEMETERY

Date: 1/12/01

20c. Location - City or Town, State: OLNEY, MD.

21. Signature of Funeral Service Licensee: Muriel H. Barber

22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic obstructive pulmonary disease — TEN YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: D. M. Hannon MD

29c. License number: D23124

29d. Date signed (Month, Day, Year): JANUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DENNIS M. HANNON MD 1396 PICCARD DRIVE, ROCKVILLE MARYLAND

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001

32. Registrar's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00883

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carrye Theone Wheeler

2. Date of Death Month / Day / Year: January 10 2001

3. Time of Death: 8:10am

4a. Facility Name *(If not institution, give street and number)*: Elternhaus

4b. City, Town, or Location of Death: Dayton

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 518 40 0910

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 5, 1912

9. Birthplace *(State or Foreign Country)*: Nebraska

Usual Residence of Decedent

10a. State: Virginia

10b. County: Nelson

10c. City, Town or Location: Montebello

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 23 Old Mill Road

10f. Zip Code: 24464

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Evans

18. Mother's Name *(First, Middle, Maiden Surname)*: Carrye Grant

19a. Informant's Name/Relationship *(Type, Print)*: Bonnie Musgrave/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23 Old Mill Road Montebello, Virginia 24464

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: 1-12-2001

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Sharon A Gillis - Witzke MD1044

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory failure — Approx. Interval: 1wk

Due to (or as a consequence of):

b. Dementia — Approx. Interval: yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Breast Cancer — Approx. Interval: yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* group home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H.A. Okon

29c. License number: D31172

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H.A. Okon 3460 Ellicott Center Dr 103 Ellicott City MD 21043

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

Cgf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00884

GENEVIEVE WALKER 214-07-1254

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GENEVIEVE GLADYS WALKER
2. Date of Death Month / Day / Year: 01 / 02 / 2001
3. Time of Death: 19:40
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-07-1254
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUNE 7 1909
9. Birthplace *(State or Foreign Country)*: W.VA.

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10301 CHRISTIE ROAD N.E.
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BUSINESS OFFICE RECEPTIONIST
16b. Kind of Business/Industry: RECEPTIONIST

17. Father's Name *(First, Middle, Last)*: LORENZO WALKER
18. Mother's Name *(First, Middle, Maiden Surname)*: EDITH DAVIS

19a. Informant's Name/Relationship *(Type, Print)*: LLOYD FILES BROTHER IN LAW
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12005 AMBER DRIVE S.E. CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CUMBERLAND CREMATORY
Date: JAN 4 2001
20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Myocardial Infarction — 4 days
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D36766
29d. Date signed *(Month, Day, Year)*: JANUARY 3 ,2001

2

MS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr.Vik Poonai 920 National Hwy Lavale, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 04 2001
32. Registrar's Signature: Bonnie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00885

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Reese E. Whitesell
2. Date of Death (Month, Day, Year): January 2, 2001
3. Time of Death: 1:14 AM
4a. Facility Name *(If not institution, give street and number)*: Solomons Nursing Center
4b. City, Town, or Location of Death: Solomons
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 577-40-5207
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 14 1927
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert
10c. City, Town or Location: Lusby
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 13030 Soundings Road
10f. Zip Code: 20657
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Pharmacist
16b. Kind of Business/Industry: Self Employed

17. Father's Name *(First, Middle, Last)*: Elwood E. Whitesell
18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Harrison

19a. Informent's Name/Relationship *(Type, Print)*: Catherine E. Whitesell (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13030 Soundings Road Lusby, MD 20657

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lee Crematory
Date: Jan 2 2001
20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: ▶ Gary J. Goff
22. Name and Address of Facility: Lee Funeral Home Calvert, P.A. 8125 Southern MD Blvd. Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Hydrocephalus — Lifelong
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Charles W. Bennett M.D.
29c. License number: D25156
29d. Date signed *(Month, Day, Year)*: January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles W. Bennett, MD 11845 H.G. Trueman Road Lusby, MD 20657

12

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 3 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00886

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALFRED F. WILSON
2. Date of Death (Month, Day, Year): JANUARY 2, 2001
3. Time of Death: 11:20 PM
4e. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 217-14-7762
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 19, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 11744 Ellington Drive
10f. Zip Code: 20705
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): William Wilson
18. Mother's Name (First, Middle, Maiden Surname): Eleanor ?
19a. Informant's Name/Relationship (Type, Print): Ethel W. Brown (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11744 Ellington Dr., Beltsville, MD 20705
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Md. Nat'l Mem. Park
Date: 1/9/01
20c. Location - City or Town, State: Laurel, MD
21. Signature of Funeral Service Licensee: George E. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6F

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. END STAGE CONGESTIVE HEART FAILURE

Due to (or as a consequence of):
b. SEVERE MITRAL REGURGITATION — 23 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ARTERIOSCLEROSIS

Due to (or as a consequence of):
d. HYPERTENSION

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERTY DISEASE
DIABETES MELLITUS
Recent Myocardial Infarction

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Abdul Nayeem, M.D
29c. License number: D21294
29d. Date signed (Month, Day, Year): JAN. 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL NAYEEM, MD 3450 FORT MEADE ROAD, SUITE 100, LAUREL, MD 20724

State Registrar

31. Date filed (Month, Day, Year): JAN 05 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0086-011
crn
Jerry L. Willoughby

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00887

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jerry L. Willoughby

2. Date of Death (Month, Day, Year): January 05, 2001

3. Time of Death: 12:36 P.M.

4e. Facility Name (If not institution, give street and number): Wooded area behind Waste Water Treatment Plant, Bell Street

4b. City, Town, or Location of Death: Ridgely

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 214-52-1151

6. Sex: 1☒ M 2☐ F

7. Age (in yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 7, 1950

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Caroline

10c. City, Town or Location: Preston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 22560 Havercamp Road

10f. Zip Code: 21655

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Town Engineer

16b. Kind of Business/Industry: Municipal Utilities

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Geneva Hilda Morgan Willoughby

19a. Informant's Name/Relationship (Type, Print): Donald Willoughby/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22730 Havercamp Rd., Preston, MD 21655

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Junior Order Cem.

Date: 1/9/01

20c. Location - City or Town, State: Preston, MD

21. Signature of Funeral Service Licensee: ▶ Michael F. Eskow

22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intra-oral gunshot wound

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? Limited 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1-05-2001

28b. Time of Injury: Found 1142 AM

28c. Injury at Work? 1☒ Yes 2☐ No

28d. Describe how injury occurred: subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Waste water Treatment Plant

28f. Location (Street and Number or Rural Route Number, City or Town, State): Bell Street Caroline County, Maryland

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stephen S. Radentz, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): January 06, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 9 2001

32. Registrar's Signature: ▶ B. Spates

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00888

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA ANN YOUNG
2. Date of Death (Month, Day, Year): JANUARY 2, 2001
3. Time of Death: 3:17 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-76-5732
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July22,1959
9. Birthplace (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11510 Lockwood Dr., #1A
10f. Zip Code: 20914
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): James B. Young
18. Mother's Name (First, Middle, Maiden Surname): Barbara A. Marbley

19a. Informant's Name/Relationship (Type, Print): Joyce Marbley (Aunt)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9727 Mt. Pisgah Rd., #712, Silver Spring,MD 20903

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Ash Memorial Cem. | Date: 1/8/01
20c. Location - City or Town, State: Sandy Spring, MD

21. Signature of Funeral Service Licensee: George A. Snowden Jr
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Fibrillation
Due to (or as a consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas B Ramirez MD
29c. License number: D0050728
29d. Date signed (Month, Day, Year): 1-3-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas B. Ramirez, M.D. 1500 Forest Glen Rd., Silver Spring, MD 2091

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00889

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margarita Almario Yan
2. Date of Death Month Day Year: January 8, 2001
3. Time of Death: 2:00 PM
4a. Facility Name *(If not institution, give street and number)*: 304 Sunny Brook Terrace, #711
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 095-34-3369
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov 13, 1937
9. Birthplace *(State or Foreign Country)*: Philippines

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 304 Sunny Brook Terrace, #711
10f. Zip Code: 20877
10g. Citizen of Whet Country?: Philippines

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* Filipino

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Speech Therapist
16b. Kind of Business/Industry: Health

17. Fether's Neme *(First, Middle, Last)*: Vicente Almario
18. Mother's Name *(First, Middle, Maiden Surneme)*: Rosario Pelaez

19a. Informent's Neme/Reletionship *(Type, Print)*: Graciano Yan, husband
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 304 Sunny Brook Terrace, #711 Gaithersburg, MD 20877

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory
Dete: Jan 11, 2001
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funeral Service Licensee ▶ [signature]
22. Neme end Address of Feciility: DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse *on* eech line.

Approximete Intervsl Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death)
a. Metastatic Breast Cancer — 2 Years

Due to (or es e consequence of):

Sequentielly iist conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest
b.
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier ▶ [signature]
29c. License number: D33293
29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Frederick P. Smith, MD., 5401 Western Ave.,NW, Washington,D.C. 20015-2998

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrer's Signeture ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

00-0141-045
jhm
ELLEN CARRIE
YOUNG

amend item 23a,27,28a,b,c,d,e,f per me G791 1/18/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00890

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLEN CARRIE YOUNG
2. Date of Death (Month, Day, Year): JANUARY 08, 2001
3. Time of Death: 10:38 AM
4a. Facility Name (If not institution, give street and number): 218 NORTH DIVISION STREET
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-88-2991
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 24 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 7,1976
9. Birthplace (State or Foreign Country): Maryland

Usuet Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 220 North Division Street
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Meritel Status: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Deles:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): -
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Dancer
16b. Kind of Business/Industry: Entertainment
17. Father's Neme (First, Middle, Last): Fenton R. Young
18. Mother's Name (First, Middle, Maiden Surname): Mary Virginia Thornton
19a. Informent's Neme/Relelionship (Type, Print): Mary V. Young/Mother
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 405 Poplar Hill Av.e, Salisbury, MD 21801
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Springhill Memory Gardens
Dete: 1/12/01
20c. Location - City or Town, Stete: Hebron, MD
21. Signature of Funerel Service Licensee: ▶ Keith R Bowley
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in death): a. TUINAL (AMOBARBITAL AND SECOBARBITAL) OVERDOSE

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or es e consequenca of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Menner of Deeth: 1☐ Netural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigelion 6☐ Could not be determined

28a. Dele of Injury (Month, Day Year): found 1/8/01
28b. Time of Injury: found 9:35 A M
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject ingested drugs
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify): found at home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 218 N. Division Street Salisbury, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steled.

29b. Signeture end title of certifier: ▶ J M. Tit
29c. License number: OCME
29d. Dete signed (Month, Day, Year): JANUARY 09, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signeture: ▶ Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00891

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emmanuel James Zevgolis

2. Date of Death Month / Day / Year: January 4, 2001

3. Time of Death: 2044

4e. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-38-0744

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 29, 1930

9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 803 Jackson Road

10f. Zip Code: 20904

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1951-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanical Engineer

16b. Kind of Business/Industry: Musical Systems

17. Father's Name *(First, Middle, Last)*: James Petro Zevgolis

18. Mother's Name *(First, Middle, Maiden Surname)*: Sophia Bathinas

19a. Informant's Name/Relationship *(Type, Print)*: Lula Zevgolis / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 803 Jackson Road Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Norbeck Memorial Park

Date: 1/8/2001

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave Silver Spring, MD 20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease — Years

Due to (or as a consequence of):

c. Diabetes — Years

Due to (or as a consequence of):

d. Hypertension — Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] James A DelVecchio MD

29c. License number: D44521

29d. Date signed *(Month, Day, Year)*: January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A DelVecchio 3001 Hospital Drive Cheverly, MD 20785

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

20+1

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00892

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Loretta Mae Zimmerman

2. Date of Death: Month: Jan. Day: 1 Year: 01

3. Time of Death: 5:35 AM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 233-40-7693

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 17, 1927

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 57 Manor Drive - Apt. A3

10f. Zip Code: 21740

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Nursing

17. Father's Name (First, Middle, Last): Lester Jones

18. Mother's Name (First, Middle, Maiden Surname): Nettie Virginia Eaton

19a. Informant's Name/Relationship (Type, Print): Robert L. Zimmerman, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 57 Manor Drive, Apt. A3, Hagerstown, MD 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 1/4/01

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert L. Spencer

22. Name and Address of Facility: Eackles-Spencer Funeral Home, Harpers Ferry, WV 25425

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Acute Myocardial Infarction — 2 hrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Zimmerman, LoreHa

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael J. McCormack MD

29c. License number: 041667

29d. Date signed (Month, Day, Year): 1·1·01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. McCormack 11110 Medical Campus Rd Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 03 2001

32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00893

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth M. Andruczyk
2. Date of Death: Month January Day 11 Year 2001
3. Time of Death: 2:20 pm
4a. Facility Name (If not institution, give street and number): 2003 Bay Ridge Avenue
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 195-20-1640
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 2, 1926
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2003 Bay Ridge Avenue
10f. Zip Code: 21403
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Simon Tanavage
18. Mother's Name (First, Middle, Meiden Surname): Alice O'Connell

19a. Informant's Name/Relationship (Type, Print): Clement A. Andruczyk (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2003 Bay Ridge Avenue, Annapolis, MD 21403

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Metro Crematory
Date: 01/15 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service licensee: ▶ Kimberly S Bore
22. Neme and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hepatic Cirrhosis	1 year
Due to (or as a consequenca of): b.	Cor Pulmonale	4 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or es a consequence of): c.	Rheumatic heart disease	60 years
d.		

Part II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I.

23b. Dfd tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy tindings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Barbara L. Bean
29c. License number: D39497
29d. Date signed (Month, Dey, Year): January 12 2001

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print): BEAN Barbara. Suite 301, 900, Bestgate Road Annapolis Maryland 21401

State Registrar

31. Dete filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00894

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John P. Ayres

2. Date of Death Month Day Year: January 13, 2001

3. Time of Death: 2:30 PM

4e. Facility Name *(If not institution, give street and number)*: Franklin Woods Center

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 229-05-8252

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 26, 1920

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 7543 Ives Lane

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years; College (1-4or 5+): 2 Years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Automobile Mechanic

16b. Kind of Business/Industry: Automobile Repair

17. Father's Name *(First, Middle, Last)*: Edward L. Ayres

18. Mother's Name *(First, Middle, Maiden Surname)*: Clady Johnson

19e. Informent's Name/Relationship *(Type, Print)*: Mr. John D. Ayres (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7543 Ives Lane Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gdns.

Date: 1/17/2001

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stephanie Massey

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Stroke — 6 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D45475

29d. Date signed *(Month, Day, Year)*: 1/16/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Rahnama 6730 Holabird Avenue Baltimore, Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00895

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE ANDREW

2. Date of Death Month / Day / Year: JANUARY, 15, 01

3. Time of Death: 1:05PM

4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-07-6437

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03-14-1914

9. Birthplace *(State or Foreign Country)*: Cordova, MD

Usual Residence of Decedent

10a. State: MD.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 616 Norhurst Way

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Law Enforcement Officer

16b. Kind of Business/Industry: Law Enforcement

17. Father's Name *(First, Middle, Last)*: George Andrew

18. Mother's Name *(First, Middle, Maiden Surname)*: Emerson

19a. Informant's Name/Relationship *(Type, Print)*: Michael Andrew-son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 306 Glenrae Drive, Catonsville, MD., 21228

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Woodlawn Cemetery

Date: 01/19/01

20c. Location - City or Town, State: Easton, Maryland

21. Signature of Funeral Service Licensee: Debbie McQuay

22. Name and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death): a. VENTRICULAR TACHYCARDIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

PROSTATE CANCER

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to compilation of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K.S. RAO M.D.

29c. Licansa number: 043462

29d. Date signed *(Month, Day, Year)*: JANUARY, 15, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.S. RAO M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signatura: Linda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #5 PER F.H. G791 1-24-01-01 WR.

Certificate of Death

Reg. No. 2001 00896

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALVIN FRANCIS AUGHENBAUGH
2. Date of Death (Month, Day, Year): JANUARY 11, 2001
3. Time of Death: 10:00P.M.
4a. Facility Name (If not institution, give street and number): 13 Glenamoy Rd.
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: ~~214-18-1080~~ 214.18.1080
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10.30.1922
9. Birthplace (State or Foreign Country): Mt. Wolf, PA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13 Glenamoy Rd.
10f. Zip Code: 21093
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Amos Aughenbaugh
18. Mother's Name (First, Middle, Maiden Surname): Eleanor Fry

19a. Informant's Name/Relationship (Type, Print): Ruth L. Aughenbaugh
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Glenamoy Rd. Timonium, MD 21093

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial PK. | Date: 1/15/01
20c. Location - City or Town, State: Laurel, Md

21. Signature of Funeral Service Licensee: Mark L. Marshall
22. Name and Address of Facility: Gary L. Kaufman Fun'lHm.@ Meadowridge Mem PK.Inc. 7250 Washington Blvd. Elkridge, MD 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — Minutes

Due to (or as a consequence of):
b. Myocardial Ischemia — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D-17041
29d. Date signed (Month, Day, Year): JANUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARC I. LEAVEY, MD. 1205 York Road Ste 3B Lutherville MD 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #20b per fh G791 011701 SS

Certificate of Death

Reg. No. 2001 00897

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Shirley Ann Anderson-Clay	January 6 2001	9:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4308 Cinibar Court	Fort Washington	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
250.02.8608	1☐ M 2■ F	46 Yrs.			May 5, 1954	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	Fort Washington	1■ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4308 Cinibar Court	20744	United States of Am.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2■ Married 3☐ Widowed 4☐ Divorced	1■ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2■ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 years	6years	Attorney at Law	Legal

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Willie Earl Anderson	Caroline Yeargin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Henry Clay	4308 Cinibar Court Fort Washington, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2■ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory, Inc.	Jan.11, 2001	Beltsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John W. Latney Jr. cc0348	Latney's Funeral Home 20011 3831 Georgia Avenue, N. W. Washington, D. C.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. Breast Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2■ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5■ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Imad Tabbara	18948	January 11,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Imad Tabbara 2150 Pennsylvania Avenue, N. W., Washington, D.C. 20037

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00898

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis Bavota

2. Date of Death: Month January, Day 15, Year 2001

3. Time of Death: 2:30 PM

4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-40-2225

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): June 28, 1944

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 2823 Southbrook Road

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yes 2 ☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Sales Representative

16b. Kind of Business/Industry: Newspaper

17. Father's Name (First, Middle, Last): Francis J. Bavota, Sr.

18. Mothar's Name (First, Middle, Maiden Surname): Alice Winstead

19a. Informant's Name/Relationship (Type, Print): Doris M. Bavota (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2823 Southbrook Road Dundalk, Maryland 21222

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery Date: 1/19/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the daath. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death): a. Aspiration Pneumonia — 15 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Respiratory Failure

Due to (or as a consequence of):

c. Left Thalamic Hemorrhage

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Were autopsy findings available prior to compilation of causa of death? 1 ☐ Yas 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] / Medicine Resident

29c. Licensa number: P13139

29d. Date signad (Month, Day, Year): January, 16, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Francisco J. Perez, MD 10 North Greene St Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00899

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles A. Bernard

2. Date of Death Month / Day / Year: January 15, 2001

3. Time of Death: 2:00 AM

4e. Facility Name *(If not institution, give street and number)*: Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 051-14-9274

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 5, 1910

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 715 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Banker

16b. Kind of Business/Industry: Banking

17. Father's Name *(First, Middle, Last)*: Charles Bernard

18. Mother's Name *(First, Middle, Maiden Surname)*: Magdlean Kunzig

19e. Informant's Name/Relationship *(Type, Print)*: Carolyn Arena - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5033 Broken Oak Lane, Columbia, Maryland 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crestlawn Cemetery — Date: 1/19/01

20c. Location - City or Town, State: Marriotsville, MD

21. Signature of Funeral Service Licensee: ▶ Ann G. Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Non-small cell lung cancer — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D47009

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Phillip Stone 711 Maiden Choice Lane, Baltimore, MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: ▶ Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00900

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Aileen Benson
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 11:30AM
4a. Facility Name (If not institution, give street and number): 1913 Whistler Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-09-3110
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 5,1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1913 Whistler Avenue
10f. Zip Code: 21223
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Bank Proof Department

17. Father's Name (First, Middle, Last): Reazin Chaney
18. Mother's Name (First, Middle, Maiden Surname): Sally

19a. Informant's Name/Relationship (Type, Print): Arthur J. Benson, Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2861 Maudlin Avenue Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 1/16/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Juanita R Thomas
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Coronary Artery disease — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J Pintous
29c. License number: D51018
29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Douglas Pinto 3521 Benson Ave, Suite 210 Baltimore MD 21227

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: ▶ Barbara G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #18 per FHG792 2/12/2001 EW

Certificate of Death

Reg. No. 2001 00901

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Judith Berends

2. Date of Death: Month January Day 14 Year 2001

3. Time of Death: 1604

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-44-1230

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 6, 1943

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 723 S. DECKER AVE.

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): KEYPUNCH OPERATOR

16b. Kind of Business/Industry: BALTIMORE GAS & ELECTRIC

17. Father's Name (First, Middle, Last): MILFORD L. BERENDS

18. Mother's Name (First, Middle, Maiden Surname): PHYLLIS ~~ANN McVORY~~ Millar

19a. Informant's Name/Relationship (Type, Print): GAIL JACOBS/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 S. DECKER AVE., BALTIMORE, MD. 21224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): BALTIMORE WASHINGTON CREMATORY

Date: 1/17/2001

20c. Location - City or Town, State: LAUREL, MD.

21. Signature of Funeral Service Licensee: Robert J. Brandt 100524

22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Intracardiac shunt	14 days
Due to (or as a consequence of): b.	Atrioseptal defect	57 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease, pneumonia,

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ AA MD

29c. License number: RES.000

29d. Date signed (Month, Day, Year): January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4940 Eastern Avenue Baltimore Maryland 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00902

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clifton William Burns
2. Date of Death (Month, Day, Year): January 13, 2001
3. Time of Death: 3:00 AM
4a. Facility Name (If not institution, give street and number): 934 North Marlyn Avenue
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-10-1178
8. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 14, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 934 North Marlyn Avenue
10f. Zip Code: 21221
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Officer
16b. Kind of Business/Industry: Security

17. Father's Neme (First, Middle, Last): Callie H. Burns
18. Mother's Neme (First, Middle, Maiden Sumeme): Ella Jones

19a. Informent's Neme/Reletionship (Type, Print): Mrs. Helen Burns (Wife)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 934 North Marlyn Avenue Essex, Maryland 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Sunset Memorial Park Cem.
Dete: 1/17/2001
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Thad M. Fuchs
22. Name end Address of Feciility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one cause on eech line. (Approximate Interval Between Onset and Deeth)

Immediate Cause (Final diseese or condition resulting in deeth): e. Metastatic Prostate Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Joanna M. Saba
29c. License number: D0055867
29d. Dete signed (Month, Day, Year): January 13, 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Joanna M. Saba 22 S. Greene St Baltimore, MD 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 17 2001
32. Registrar's Signeture: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00903

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donica Ann Brown

2. Data of Death — Month: January Day: 13 Year: 2001

3. Time of Death: 0245

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 564-24-1359

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): July 12, 1924

9. Birthplace (State or Foraign Country): Yugoslavia

Usual Rasidence of Decedant

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1105 Boucher Avenue

10f. Zip Code: 21403

10g. Citizan of What Country?: USA

11. Maritel Status: 1☐ Nevar Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yeer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completad)

Elamantary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama (First, Middle, Last): John Lubich

18. Mothar's Nama (First, Middle, Maiden Surnama): Mary Madzar

19a. Informant's Name/Ralationship (Type, Print): Raleigh Brown (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 148 Cornell Street, Windsor, CA 95492

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cemetary, cramatory or othar placa): Metro Crematory

Data: 01/17 2001

20c. Location - City or Town, Steta: Baltimore, MD

21. Signatura of Funaral Service Licensee: Michael P. Hatta

22. Nama and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Between Onset and Death

Immedieta Causa (Finat disaasa or condition resulting in death)

a. non ventilating left lung — Days

Due to (or as a consequence of):

b. mucous plugging — Days or weeks

Sequentially list conditions, if eny, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse givan in Part I.

emphysema

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of ceusa of death? 1☐ Yas 2☒ No

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Death (Check only ona)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Phyeician:** To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated. 2☐ **Medicat Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to tha causa(s) and mannar stated.

29b. Signature and title of certifier: KEVIN KNOPF MD

29c. License number: D51301

29d. Data signed (Month, Day, Year): January 13 2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print): 900 Bestgate Road Suite 300 Annapolis, MD 21401

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00904

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTHA BAXTER
2. Date of Death (Month, Day, Year): JANUARY 16th 2001
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 249-40-5876A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-27-10
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3308 Hillen Road
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th Grade
College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-employed
16b. Kind of Business/Industry: Baxter Nursing Home

17. Father's Name (First, Middle, Last): Willie Salley
18. Mother's Name (First, Middle, Maiden Surname): Kittie Milhouse

19a. Informant's Name/Relationship (Type, Print): Celestine Morgan
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218: 3308 Hillen Road Baltimore, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Dorcas Cemetery
Date: 01-20-01
20c. Location - City or Town, State: North Carolina South

21. Signature of Funeral Service Licensee: ▶ Gladys Wane
22. Name and Address of Facility: Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: P-12560
29d. Date signed (Month, Day, Year): JANUARY 16th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANU GABA, 5601, LOCH RAVEN BLVD, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00905

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN R. BALLARD SR.
2. Date of Death: Month JAN. Day 11 Year 2001
3. Time of Death: 5:30PM
4a. Facility Name (If not institution, give street and number): 911 LEADENHALL ST., APT. #204
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 248-14-3411
6. Sex: 1 [X] M 2 [ ] F
7. Age (If yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 16, 1918
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 911 LEADENHALL ST. APT. #204
10f. Zip Code: 21230
10g. Citizen of What Country? USA.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3RD GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOREMAN
16b. Kind of Business/Industry: INDIANA GRAIN BUREAU

17. Father's Name (First, Middle, Last): VICTOR BALLARD
18. Mother's Name (First, Middle, Maiden Surname): CHARLOTTE (MN-UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): DONALD BALLARD (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 LEADENHALL ST., APT. 204, BALTO. MD. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK
Date: 01-17-01
20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death):
a. ACUTE MYOCARDIAL ATTACK

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. DIABETES MELITUS MULT. ORGAN INVOLVEMENT AK-C

Due to (or as a consequence of):
d. C.V.A (R) W/ Hemiplegia (L)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
A-S-C-V-D.
CHRONIC CYSTITIS
CHRONIC RENAL FAILURE - DUE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: CARLOS N. PATALINGHUG MD
29c. License number: D19426
29d. Date signed (Month, Day, Year): 1/15/01
30. Name and address of person who completed cause of death (item 23e) (Type, Print): 4115 RITCHIE HWY - BALT. MD 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [illegible] Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00906

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLARENCE R. BALL II

2. Data of Death Month: January Day: 16 Year: 2001

3. Time of Death: 1:03 AM

4a Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-26-0939

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 15, 1918

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 2402 ELSINORE AVENUE

10f. Zip Code: 21216

10g. Citizen of What Country? USA.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4yrs

College (1-4or 5+): (B.S)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR

16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): CLARENCE R. BALL

18. Mother's Name (First, Middle, Maiden Surname): MARTHA BALL

19a. Informent's Name/Relationship (Type, Print): GLADYS BALL (WIFE)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2402 ELSINORE AVE. BALTIMORE, MD. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): MD. NATIONAL CEMETERY

Date: 1-20-01

20c. Location - City of Town, State: LAUREL, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gastrointestinal Bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Aspiration of stomach contents

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yaa 2 [ ] No 3 [ ] Probably [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D0053312

29d. Date signed (Month, Day, Year): January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 900 Caton Avenue, Baltimore, maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ball, Clarence
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00907

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES WASHINGTON BALL

2. Date of Death — Month: JAN. Day: 11 Year: 2001

3. Time of Death: 2:45 P.M.

4e. Facility Name (If not institution, give street and number): JOSEPH RITCHIE HOSPICE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-26-5578

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 22, 1925

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3 CASEY COURT

10f. Zip Code: 21228

10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 11TH GRADE — College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FISHING

16b. Kind of Business/Industry: COMMERCIAL FISHING

17. Father's Name (First, Middle, Last): ROBERT ALLEN BALL

18. Mother's Name (First, Middle, Maiden Surname): KATHERINE SMITH

19a. Informant's Name/Relationship (Type, Print): BEULAH BALL (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 CASEY COURT, BALTIMORE, MD. 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE NATIONAL — Date: 01-16-01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Squamous cell carcinoma of the lung — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Type 1 diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ G. William Benedict MD

29c. License number: D000 8583

29d. Date signed (Month, Day, Year): 01/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G. WILLIAM BENEDICT, 6565 N. CHARLES ST. BALTIMORE, MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

2:45pm

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

James Ball 1/11/01

01-0183-510
LRB
Norman Brialey

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00908

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NORMAN BRAILEY
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 12:45 P.M.
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-36-8746
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-09-1940
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2405 BAKER ST
10f. Zip Code: 21216
10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RECREATION SUPERVISOR
16b. Kind of Business/Industry: STATE GOVERNMENT

17. Father's Name (First, Middle, Last): TROY F. BRAILEY
18. Mother's Name (First, Middle, Maiden Surname): CHESSIE GRANGER

19a. Informant's Name/Relationship (Type, Print): CHESSIE M. BRAILEY, MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2405 BAKER ST, BALTO. MD 21207

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): ARBUTUS MEMORIAL PK | Date: 1-17-00
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶Willie E Howell Jr
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequance of):

d.

Part II. **Other signifficant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? Inspection 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Homa 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and mannar as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and piace, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶Stephen Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00909

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Brocato

2. Date of Death (Month, Day, Year): January 15, 2001

3. Time of Death: 10:05AM

4a. Facility Name (If not institution, give street and number): Catonsville Commons Nursing Home

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-16-9213

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08-03-1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1 West Conway Street Apt.1201

10f. Zip Code: 21201

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yeer or Detas:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - American Indien, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Homemaker

16b. Kind of Businass/Industry: OWN HOME

17. Fathar's Nama (First, Middla, Last): Anthony Geppi

18. Mothar's Nama (First, Middla, Maidan Surnama): Rosalie D'Anna

19a. Informant's Name/Ralationship (Type, Print): Sandy Zitzer- Sister

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 2504 Amber Orchard Court-West #301, Odenton, Maryland

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): New Cathedral Cemetery

Data: 01/18/2001

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Servica Licensae: Valorie M Davis

22. Name and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Aveune, Catonsville, Maryland 21228

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complicetions that caused the daath. Do not anter the mode of dying, such as cardiac or raspiratory errast, shock, or haert failura. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Death

Immediata Causa (Final diseasa or condition resulting in daath): a. Metastatic Cancer — Approx. Onset: Months

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in death) Last:

b. Dua to (or as a consequence of):

c. Dua to (or as e consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings aveilable prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Sulcida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and menner stated.

29b. Signeture and titla of certifiar: B. Turakhia M.D.

29c. License number: D36942

29d. Deta signed (Month, Day, Year): January 15, 2001

30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print): B. Turakhia, 1009, Frederick Rd. Catonsville, MD 21228

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00910

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE LIMA BRANDT

2. Date of Death: Month JANUARY Day 14 Year 2001

3. Time of Death: 10:10 AM

4a. Facility Name (If not institution, give street and number): CROFTON CONVALESCENT CENTER

4b. City, Town, or Location of Death: CROFTON

4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 220-38-5550

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan.23 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Howard County

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11440 Little Pataxent Parkway Apt.704

10f. Zip Code: 21044

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home Owner

17. Father's Name (First, Middle, Last): Andrew Twomey

18. Mother's Name (First, Middle, Maiden Surname): Johannah Costello

19a. Informant's Name/Relationship (Type, Print): Peggy Brandt (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 740 Medinah Circle, Westminister, Md. 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery Date: 01/18/2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Aspiration Pneumonia	1 week
Due to (or as a consequence of): b.	End Stage Alzheimer's disease	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D22028

29d. Date signed (Month, Day, Year): 1-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul S. Rhodes, M.D. 1667 Crofton Centre' Crofton, MD 21114

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Henry Britenstine
mnmr
01-0244-510
amend item 23a,27,28a,b,c,d,e,fper me G791 1/18/01 yf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00911

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY LEE BRITENSTINE
2. Data of Death Month Dey Yeer: January 14, 2001
3. Time of Death: 2102 pm
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-66-2652
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 45 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): MAY 14, 1955
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: SEVERN
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8220 QUARTERFIELD ROAD
10f. Zip Code: 21144
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Datas: UN-KNOWN
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bieck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grada completed): Elementery/Secondery (0-12); College (1-4or 5+): 2
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSTRUCTION
16b. Kind of Business/Industry: INDUSTRIAL

17. Father's Name (First, Middle, Last): EDGAR BRITENSTINE
18. Mother's Name (First, Middle, Meiden Surneme): MARTHA ARNODT

19a. Informent's Neme/Reletionship (Type, Print): MARTHA BRITENSTINE (MOTHER)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 8220 QUARTERFIELD ROAD, SEVERN, MD. 21144

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or othar piece): CHESAPEAKE CREMATION CENTER, LLC. Date: 1/18/2001
20c. Location - City or Town, Stete: STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. — Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth): a. THERMAL INJURIES WITH COMPLICATIONS

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
b. Due to (or as e consequenca of):
c. Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causs of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [X] Yes 2 [ ] No
26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [ ] Neturel 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Yeer): 12/21/00
28b. Time of Injury: 8:40 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: victim of house fire
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify): residence
28f. Location (Street and Number or Rurel Route Number, City or Town, State): 2008 N. Payson Street Baltimore, Maryland

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and menner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated.
29b. Signature and title of certifier: [signature] J M. Tit
29c. Licanse number: O.C.M.E.
29d. Data signed (Month, Day, Yeer): January 15, 2001
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Dey, Yeer): JAN 17 2001
32. Registrer's Signeture: [signature] Geneva L Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00912

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY FRANCES BROWN
2. Date of Death (Month, Day, Year): January 11 2001
3. Time of Death: 1:35 Am.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 232-28-4803
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 18, 1907
9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1006 THOMAS RD.
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPER
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): JOHN WILLIS
18. Mother's Name (First, Middle, Maiden Surname): LELA DOTSON

19a. Informant's Name/Relationship (Type, Print): NANCY DONNELLY (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1006 THOMAS RD., GLEN BUNRIE,MD, 21060

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION
Date: JAN. 14 2001
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: [signature] M00264
22. Name and Address of Facility: SINGLETON FUNERAL HOME,P.A. 1 SECOND AVE.S.W., GLEN BURNIE,MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ENTEROCOCAL SEPSIS.
Due to (or as a consequence of):
b. BILIARY OBSTRUCTION.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D43677
29d. Date signed (Month, Day, Year): January 11 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anoken Dhungel 39 Hospital Drive, Glen Burnie MD 21720

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature] G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

MARM BROWN

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00913

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert James Brown, Jr
2. Date of Death Month / Day / Year: 1 / 14 / 2001
3. Time of Death: 2:30 Pm
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: N/A
6. Sex: 1 M 2 F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months / Days: 17; If Under 24 Hrs. Hours / Min.:
8. Date of Birth (Month, Day, Year): 12/29/2000
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedant

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 Yes 2 No
10e. Street and Number: 101 N. Fulton Avenue
10f. Zip Code: 21223
10g. Citizen of What Country?: U.S

11. Marital Status: 1 Navar Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Yas 2 No Specify:
14. Raca - American Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12): N/A College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): N/A
16b. Kind of Business/Industry: N/A

17. Fathar's Name (First, Middle, Last): Robert James Brown
18. Mothar's Nama (First, Middle, Maidan Sumama): Lillian Jackson

19a. Informant's Name/Relationship (Type, Print): Betty Pettigrew Great grandmother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 637 N. Rosedale Balto MD 21216

20a. Mathod of Disposition: 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify)
20b. Place of Disposition (Nama of cematery, crematory or othar placa): Greenmount
Date: 1/17/01
20c. Location - City or Town, Stata: Balto. MD

21. Signature of Funaral Service Licensee: Irvin Carroll
22. Nama and Address of Facility: Irvin Carroll Funeral Home 1712 W. North Avenue Balto MD 21217

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath): a. Trisomy 13 — 17 days
Dua to (or as a consequanca of):
Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disease or injury that initiated avants resulting in daath) Last:
b. Dua to (or as a consequanca of):
c. Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yas 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yas 2 No

25. Was casa rafarrad to medical examinar? 1 Yas 2 No
26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify)
27. Mannar of Death: 1 Natural 2 Accident 3 Suicida 4 Homicida 5 Pending investigation 6 Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 Yas 2 No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifier (Check only one): 1 **Certifying Physician:** To the best of my knowledga, daath occurrad at the time, data and placa, and due to tha cause(s) and mannar as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurrad at the tima, data and placa, and due to the ceuse(s) and mannar stated.
29b. Signature and title of certifier: Neonatology
29c. Licansa number: D48175
29d. Date signed (Month, Day, Year): 1/16/01
30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Andres Rodriguez 22 S Green St, Baltimore, MD

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00914

BLANKENSHIP, JESSIE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Neme (First, Middle, Last)			2. Dete of Deeth Month	Dey	Year	3. Time of Death
Jessie	L.	Blankenship	JANUARY	15	2001	5:11 PM

4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
FRANKLIN SQUARE HOSPITAL CENTER	ROSEDALE	BALTIMORE

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yeer Months	If Under 1 Yeer Deys	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthpleca (Stete or Foreign Country)
233-40-6085	1☐ M 2☒ F	72 Yrs.					Apr. 2, 1928	WV.

Usuel Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Baltimore	Essex	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
100 Kingsley Rd.	21221	USA

11. Meritel Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	Collège (1-4or 5+)		
12 yrs.		Housewife	Own Home

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Wanego Harry	Blanche L. Davis

19e. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Melissa Smitley Daughter	18 Duchess Ct. White Marsh, Md. 21237

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Garrison Forrest Cem	Jan 22, 2001	Owings Mills, Md.

21. Signeture of Funerel Service Licensee	22. Neme end Address of Fecility
▶ Anthony C. Connelly	Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one cause on each line.

		Approximete Intervel Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CARCINOMA WITH METASTATIC	33 DAYS
	Due to (or as a consequence of):	
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Dey, Yeer)
▶ Haider Sarraf MD	RD 203307	1-15-01

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)
DR. HAIDER SARRAF 9000 FRANKLIN SQUARE DRIVE MD. 21237

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrer's Signeture
JAN 17 2001	▶ Jeneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00915

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SARA BRYANT

2. Date of Death — Month: JANUARY Day: 12 Year: 2001

3. Time of Death: 1119 AM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 225-24-9964

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 28, 1924

9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Pa.

10b. County: York

10c. City, Town or Location: Delta

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 283 Pine Trail

10f. Zip Code: 17314

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 Yrs.

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker

16b. Kind of Business/Industry: Glass/Paper

17. Father's Name (First, Middle, Last): Charles Anderson

18. Mother's Name (First, Middle, Maiden Surname): Alice Rita Duff

19a. Informant's Name/Relationship (Type, Print): Richard Dawson Son-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 283 Pine Trail, Delta, Pa. 17314

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Cemetery

Date: Jan. 16 2001

20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral Service Licensee: John E. Mills Jr

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers POint Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEMORRAGIC SHOCK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. AORTIC DISRUPTION

Due to (or as a consequence of):

c. THORACO-ABDOMINAL ANEURYSM

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☒ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Justin Somerville MD

29c. License number: 12452

29d. Date signed (Month, Day, Year): JANUARY 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUSTIN SOMERVILLE UNIVERSITY OF MARYLAND MEDICAL SYSTEM

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Emma G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS #2 & 29d per phys G791 011701 SS

Certificate of Death

Reg. No. 2001 00916

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gordon E. Brown

2. Date of Death: Month January Day 13, ~~2000~~ Year 2001

3. Time of Death: 8:15AM

4a. Facility Name (If not institution, give street and number): Mercy Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: =215-30-7841

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 6,1935

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1515 Retreate Street

10f. Zip Code: 21217

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: W.R.Grace Davidson

17. Father's Name (First, Middle, Last): Raymond Brown

18. Mother's Name (First, Middle, Maiden Surname): Estelle Coates

19a. Informent's Name/Reletionship (Type, Print): Belinda Brown/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1515 Retreate St.Balto.,Md 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Arbutus Cemetery

Date: Jan.19,2001

20c. Location - City or Town, State: Balto.Md

21. Signature of Funerel Service Licensee: Calvin B Scruggs Jr.

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO. MD @!21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. Pancreatic Cancer — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr Rusberg MD

29c. License number: D40854

29d. Date signed (Month, Day, Year): 1/15/~~2000~~ 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Rusberg MD 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Deputy G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00917

BUIE, Robert

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Alexander Buie
2. Date of Death: Month: January Day: 8 Year: 2001
3. Time of Death: 7:25 P.M.
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 700-18-7161
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/15/1922
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: -
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1114 N. Fulton Ave.
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Janitorial
16b. Kind of Business/Industry: unk.

17. Father's Name (First, Middle, Last): Benson A. Buie
18. Mother's Name (First, Middle, Maiden Surname): Isabella D'berry

19a. Informant's Name/Relationship (Type, Print): Lucy Cousins-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1521 N. Collington Ave. 21213 Baltimore, MD

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Cemetery
Date: 1/17/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Timothy Miller
22. Name and Address of Facility: Miller Metropoletan Chapel P.A. 1639 E. Belvedere Ave. Balt. MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Ventricular Tachycardia
Due to (or as a consequence of):
Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c. Diabetes Mellitus
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD.
29c. License number: D43977
29d. Date signed (Month, Day, Year): January 8 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anyoka Okerinyo. 301 Hospital Drive, Glen Burnie. MD 21061.

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00918

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Riley Junior Byrne

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 12:30 P.M.

4e. Facility Name (If not Institution, give street and number): 1225 Primrose Avenue

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 197-10-2648

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 26, 1916

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 1225 Primrose Avenue

10f. Zip Code: 21237

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant

16b. Kind of Business/Industry: Board of Education

17. Father's Name (First, Middle, Last): Riley M. Byrne

18. Mother's Name (First, Middle, Maiden Surname): Anna Unknown

19e. Informent's Name/Relationship (Type, Print): Mary Byrne / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1225 Primrose Avenue Baltimore MD 21237

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Balto/Wash Crematory

Date: 1/16/2001

20c. Location - City or Town, State: Laurel MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CA COLON

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN

CAD

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sohail Mostafa Qarni MD

29c. License number: D-48025

29d. Date signed (Month, Day, Year): 1-15-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SOHAIL M. QARNI MD 1224 CHESACO AVE, Balto, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #20B PER F.H. G791 1-17-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00919

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1. Decedent's Name (First, Middle, Last): Adrian Cheatham
2. Date of Death (Month, Day, Year): January 11 2001
3. Time of Death: 19:40
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: NA
5. Social Security Number: 215-82-9390
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 39 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-27-61
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 252 Dallas Court
10f. Zip Code: 21202
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: various trades
17. Father's Name (First, Middle, Last): William Brown
18. Mother's Name (First, Middle, Maiden Surname): Viola Anderson
19a. Informant's Name/Relationship (Type, Print): Lynette Womack
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1529 Leslie Street Baltimore, Maryland 21217
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of Cemetery, crematory or other place): ~~Valley Memorial Gardens~~ Greenmount Cemetery
Date: 01-16-2001
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. pneumonia — 2 weeks

Due to (or as a consequence of):
b. Streptococcus bacteremia (Strep pneumococcus) — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. pneumothorax with chest tube placement — 8 days

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HIV positive

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Erin Donnelly, MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 600 North Wolfe Street Baltimore Maryland 21287

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00920

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STERLING E. COMEGYS SR.
2. Date of Death (Month, Day, Year): JANUARY 16, 2001
3. Time of Death: 5:45 AM
4a. Facility Name (If not institution, give street and number): STELLA MARIS AT MERCY HOSPICE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-52-2712
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 10, 1950
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1316 MCHENRY STREET
10f. Zip Code: 21223
10g. Citizen of What Country?: USA.

11. Meritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: DICKS VENDING CO.

17. Father's Name (First, Middle, Last): JOHN MCGRAW
18. Mother's Neme (First, Middle, Maiden Sumame): DORIS COMEGYS

19a. Informant's Name/Relationship (Type, Print): CHRISTINE COMEGYS (SISTER-IN-LAW)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1316 MCHENRY STREET, BALTO, MD-21223

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY | Date: 01-22-01
20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Deeth)

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of Penis

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): Hospice

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] ~~Certifying Physician~~: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D40854
29d. Date signed (Month, Day, Year): JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St PAUL PL BALTIMORE MD 21202

State Registrar

31. Dete filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00921

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RENAULT E COOK

2. Date of Death (Month, Day, Year): JANUARY 12, 2001

3. Time of Death: 4:00PM

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Balto City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-74-6791

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-10-1959

9. Birthplace (State or Foreign Country): BALTO.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3802 HILLSDALE AVE

10f. Zip Code: 21207

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISABLED

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): RALPH COOK

18. Mother's Name (First, Middle, Maiden Surname): MARY DAVIS

19a. Informant's Name/Relationship (Type, Print): MARY COOK, MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3802 HILLSDALE AVE, BALTIMORE, MD 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK

Date: 1-17-01

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Willie E Howell Jr

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. acute upper gastrointestinal bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Aids, seizure disorder

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: 019695

29d. Date signed (Month, Day, Year): 1-12-01

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): Saul Urcinreb 6305 Fairlawn Dr. Baltimore Md 21209

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ D Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00922

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TIMOTHY I COLEMAN
2. Date of Death: Month 1 Day 11 Year 01
3. Time of Death: 1:10 pm
4e. Facility Name (If not institution, give street and number): 7307 Prince George Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-12-8854
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 14, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7307 Prince George Road
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: NOV 10,42 Dec 12,45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic
16b. Kind of Business/Industry: Auto

17. Father's Name (First, Middle, Last): Robert Coleman
18. Mother's Name (First, Middle, Maiden Surname): Mabel EBB

19a. Informant's Name/Relationship (Type, Print): Gwendolyn N. Coleman/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7307 Prince George Rd. Balto. MD, 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Garrison Forest Veteran — Date: Jan 19-01
20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: ▶ Ronald A Grayson
22. Name and Address of Facility: Ronald A. Grayson Funeral Service 8312 Liberty Road Baltimore MD, 21244

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Advanced COPD (chronic obstructive pulmonary D/S
Due to (or as a consequence of):
b. Prostate Cancer
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Cerebrovascular accident
Due to (or as a consequence of):
d. Probable Colon cancer

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Dementia
Failure to thrive

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ S. Abate MD
29c. License number: D50296
29d. Date signed (Month, Day, Year): 1/12/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHASTINE ABATE 4 West Rolling Rd Catonsville MD 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: ▶ Jeanne S Sparks

5

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Case # 1613967

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00923

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Martin Demek
2. Date of Death — Month: January Day: 13 Year: 2001
3. Time of Death: 1801
4a. Facility Name *(If not institution, give street and number)*: University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-12-7558
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 28 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1708 S. Charles Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Fire Chief
16b. Kind of Business/Industry: Baltimore City

17. Father's Name *(First, Middle, Last)*: Martin Demek
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Stumpf

19a. Informant's Name/Relationship *(Type, Print)*: Marie A. Crosby (Sister)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1708 S. Charles Street, Baltimore, Md. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Cross Cemetery — Date: 01/18/2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Richard Pickett
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Respiratory Failure
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Menaker MD
29c. License number: 13041
29d. Date signed *(Month, Day, Year)*: January 13 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Menaker Md. 22 S. Greene Street University Of Md. Baltimore, Md. 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00924

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Drumheller

2. Data of Death: Month JANUARY Day 09 Year 2001

3. Time of Death: 5:50 AM

4a Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219 18 5096

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 12, 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4210 Audrey Avenue

10f. Zip Code: 21225

10g. Citizen of What Country? U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Unknown Walsh

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Wanda Wood / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4210 Audrey Avenue Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): MD State Veteran Cem.

Data: 1/12/01

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Shannon M Liggett

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrythmia — 20 minutes

Due to (or as a consequence of):

b. Congestive Heart Failure — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

CORONARY ARTERY DISEASE

DIABETES MELLITUS

23b. Did tobacco use contributa to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter Craig MD

29c. License number: P14427

29d. Date signed (Month, Day, Year): JANUARY 09 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Craig MD, 3001 South Hanover Street, Baltimore, Maryland 21225

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00925

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES DILL
2. Date of Death: Month JANUARY Day 14 Year 2001
3. Time of Death: 4:22 AM
4a. Facility Name (If not institution, give street and number): 39 COLONIAL DRIVE
4b. City, Town, or Location of Death: LINTHICUM
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 220-07-4231
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 08, 1919
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: LINTHICUM
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 39 COLONIAL DRIVE
10f. Zip Code: 21090
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MILKMAN
16b. Kind of Business/Industry: DAIRY
17. Father's Name (First, Middle, Last): CHARLES F. DILL
18. Mother's Name (First, Middle, Meiden Surneme): SADIW GUMPMAN
19a. Informent's Name/Relationship (Type, Print): MRS. ANNA LEE DILL (WIFE)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 39 COLONIAL DRIVE, LINTHICUM, MARYLAND 21090
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other placa): CHESAPEAKE CREMATION CENTER, LLC, STEVENSVILLE, MD.
Dete: JAN. 17/2001
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: M01220
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in deeth)	a. Lung cancer	6 wks.
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or es e consequenca of):	
	c.	
	Due to (or as a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1 [ ] Yee 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Grannan M.D
29c. License number: D39505
29d. Data signed (Month, Dey, Yeer): Jan. 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Judith Marmon 1600 Crain Hwy, Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00926

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
THOMAS	ROLAND	DRURY	JANUARY 10, 2001	6:50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL ASSOCIATION	GLEN BURNIE	ANNE ARUNDEL

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-50-9644	1 [X] M 2 [ ] F	52 Yrs.			MAR. 23, 1948	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	SEVERN	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8022 FAIR BREEZE DRIVE	21144	u.s.a.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [ ] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	MANAGER	SALES

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
ROLAND	DRURY	MILDRED	COX

19a. Informent's Name/Reletionship (Type, Print)	19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. MARGARET DRURY (WIFE)	8022 FAIR BREEZE DRIVE, SEVERN, MARYLAND 21144

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	CHESAPEAKE CREMATION CENTER, LLC.	1/13/2001	STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	1 hour
Due to (or as a consequence of):	b. Arteriosclerotic Cardiovascular Disease	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. End Stage Renal Disease	2 years
Due to (or as a consequence of):	d. Diabetes Mellitus	20 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer?	26. Plece of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] Elliott Gorbaty MD	D20094	01/10/01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)
Elliott Gorbaty MD 7845 Oakwood Rd, Glen Burnie md, 21061

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	[signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00927

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Daly
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 0631
4a. Facility Name (If not institution, give street and number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 159-34-9382
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06 17 1942
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1136 Hanover Street
10f. Zip Code: 21230
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Beady
18. Mother's Neme (First, Middle, Maiden Sumeme): Catherine Eaton

19a. Informant's Name/Relationship (Type, Print): Sean Daly/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Brookstone Pl, Aliso Viejo, CA 92656

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sts. Peter & Paul Cem
Date: 01/16/01
20c. Location - City or Town, State: Springfield, Pa

21. Signature of Funeral Service Licensee: Stephanie Allen
22. Neme and Address of Fecility: Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Carcinoma — 2 years
Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease
Coronary Collitis

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier
29c. License number: D53283
29d. Date signed (Month, Day, Year): 1/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Isles 1117 South Hanover St Baltimore MD 21230

State Registrar

31. Dete filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00928

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Calvin Norman Luck Echard
2. Date of Death: Month January, Day 16, Year 2001
3. Time of Death: 12:05 am
4a. Facility Name (If not institution, give street and number): Crofton Convalescent Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-22-3897
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): June 5, 1925
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severn
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1159 Thompson Avenue
10f. Zip Code: 21144
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Repair
16b. Kind of Business/Industry: TV

17. Father's Name (First, Middle, Last): Unknown Echard
18. Mother's Name (First, Middle, Maiden Surname): Bessie Unknown

19a. Informant's Name/Relationship (Type, Print): Doris L. Echard (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1159 Thompson Avenue, Severn, MD 21144

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 01/17/2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Michael P. Kutta
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary artery disease — 2 years
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D38958
29d. Date signed (Month, Day, Year): 1/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daljeet S. Sidhu, MD, 1413 Annapolis Road, Odenton, MD 21113

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Jeanette G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#4a perPHYG791 1/17/2001 EW

Certificate of Death

Reg. No. 2001 00929

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pauline Mary Eccleston
2. Date of Death Month Day Year: January 6 2001
3. Time of Death: 11:54 pm
4a. Facility Name (If not institution, give street and number): ~~606 Earls Road~~ 424 Earls Road
4b. City, Town, or Location of Death: Baltimore County
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217 26 5283
6. Sex: 1☐ M 2☐ F X
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 20 1910
9. Birthplace (State or Foreign Country): Baltimore Co., MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☐ No X
10e. Street and Number: 424 Earls Road
10f. Zip Code: 21220
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Worker
16b. Kind of Business/Industry: Baltimore County Dept. of Education

17. Father's Name (First, Middle, Last): Peter Alphonso Comes
18. Mother's Name (First, Middle, Maiden Surname): Anna Catherine Tremper

19a. Informant's Name/Relationship (Type, Print): Evelyn M Asher (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 Earls Road Baltimore, Maryland 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Cemetery
Date: January 8 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Lassahn Chappell
22. Name and Address of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ALZHEIMERS DISEASE — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jim Parshall
29c. License number: D4000 8
29d. Date signed (Month, Day, Year): 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JIM PARSHALL 9105 FRANKLIN SQUARE DR, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VOID

CERTIFICATE #

2001-0930

SEE

CERTIFICATE #

2000-43456

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00931

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eunice Fine

2. Date of Death (Month, Day, Year): January 12, 2001

3. Time of Death: 9:45 PM

4a. Facility Name (If not institution, give street and number): 5234 Carroll Warehime Road

4b. City, Town, or Location of Death: Lineboro

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 286-24-6532

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 7. 1919

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Lineboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5234 Carroll Warehime Road

10f. Zip Code: 21088

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Mike Morich

18. Mother's Name (First, Middle, Maiden Surname): Lillian McKinley Reynolds

19a. Informant's Name/Relationship (Type, Print): Brenda S. Gottleib/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5234 Carroll Warehime Road Lineboro, Maryland 21088

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park

Date: 1/15/01

20c. Location - City or Town, Stete: Elkridge, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Cancer of Pancreas — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: INTERNIST MD

29c. License number: D 52035

29d. Date signed (Month, Day, Year): Jan 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BINO CHACKO 291 Stoner Avenue Dixon Building Westminister MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00932

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marvin Ford

2. Date of Death: Month JAN Day 11 Year 2001

3. Time of Death: 1000 pm

4a. Facility Name (If not Institution, give street and number): STAGNESS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 243-44-7427

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-22-1933

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3800 W. Belvedere Ave

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 10th grade

College (1-4or 5+): NA

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Disabled

16b. Kind of Business/Industry: NA

17. Father's Neme (First, Middle, Last): J. B. Ford

18. Mother's Neme (First, Middle, Maiden Surneme): Pinkey

19e. Interment's Name/Reletionship (Type, Print): Carlene A. Ford - wife

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 3800 W. Belvedere Avenue Apt 810 Balto, Md 21215

20a. Method ot Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece ot Disposition (Name of cemetery, crematory or other piece): Metro Crematory

Date: 1/16/01

20c. Location - City or Town, Stete: Catonsville, Md

21. Signeture of Funerel Service Licensee: Glynn B. Kelly

22. Neme end Address of Facility: March F.H. West 4300 Wabash Ave Balto, Md 21215

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode ot dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. ADRENAL CRISIS

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

Due to (or es e consequence ot):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

HYPERTENSION

ABDOMINAL AORTIC ANEURISM

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Dete ot Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner es steted. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Internal Med Attending

29c. License number: D0054433

29d. Date signed (Month, Dey, Year): JAN 11, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): 600 CATON AVE BALTIMORE, MD

State Registrar

31. Dete filed (Month, Day, Year): JAN 17 2001

32. Registrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

NAME MARVIN FORD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00933

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilmer Joseph Freeland, Sr.

2. Date of Death: Month Jan. Day 16, Year 2001

3. Time of Death: 7:20 pm

4a. Facility Name (If not institution, give street and number): Westminster Nursing and Conv. Center

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-03-5210

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 26, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8828 Orchard Rd.

10f. Zip Code: 21208

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Parts Manager

16b. Kind of Business/Industry: Sewing Company

17. Father's Name (First, Middle, Last): James Sheldon Freeland

18. Mother's Name (First, Middle, Maiden Surname): Ida Mae Badders

19a. Informant's Name/Relationship (Type, Print): Patricia A. Wertz - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16 E. Pleasant Hill Rd., Owings Mills, Md. 21117

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Mem. Gardens | Date: Jan. 19, 2001 | 20c. Location - City or Town, State: Finksburg, Md.

21. Signature of Funeral Service Licensee: H.J. Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. acute Myocardial Infarction	15 min
Due to (or as a consequence of)	b. ASCVD	25 yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Dementia - Alzheimers	5 yr
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Middleton MD

29c. License number: D25443

29d. Date signed (Month, Day, Year): 1-17-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Rd, Westminster Md 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Funeral Director or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00934

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Joseph Fabrick, Sr.
2. Data of Death — Month: Jan. Day: 16 Year: 2001
3. Time of Death: 2:05 AM
4a. Facility Nema (If not institution, giva street and number): Westminster Nursing and Conv. Ctr.
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-16-6996
6. Sex: 1 ☒ M 2 ☐ F
7. Aga (In yrs. last birthday): 75 Yrs. — If Under 1 Yaer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Deta of Birth (Month, Day, Year): April 9, 1925
9. Birthplaca (State or Foraign Country): Maryland

Usual Residance of Decedent

10e. Stata: Md.
10b. County: Carroll
10c. City, Town or Location: Finksburg
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3225 Old Westminster Pike
10f. Zip Coda: 21048
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Dacedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No — If Yas, Giva Yaer or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 ☐ Yes 2 ☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, atc. Specify: White
15. Decedent's Education (Specify only highast grade complated): Elamantary/Secondary (0-12): 3 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratirad): Heavy Equipment Operator
16b. Kind of Businass/Industry: Construction
17. Fathar's Nama (First, Middla, Last): Vincent Joseph Fabrick
18. Mothar's Nama (First, Middla, Maidan Surnama): Mary Hare
19a. Informant's Name/Ralationship (Type, Print): Ronnie E. Fabrick - Stepson
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1027 Yukon Court, Jacksonville, N. Carolina 28546
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Piece of Disposition (Nama of camatary, crematory or othar placa): Metro Crematory — Data: Jan. 19, 2001
20c. Location - City or Town, Steta: Baltimore, Md.
21. Signatura of Funaral Service Licensea: J Gill Eckhardt
22. Nama and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. — Approximata Intarval Batween Onset and Daath

Immediata Causa (Final disaasa or condition rasulting in daath):
a. Acute Myelogenous Lukemia — 1m
Dua to (or as a consequanca of):
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last
b.
Dua to (or as a consequanca of):
c.
Dua to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No

24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yas 2 ☑ No

26. Placa of Daath (Chack only ona) — Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — Othar: 4 ☑ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Panding Investigation 6 ☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To tha best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: INTERNIST, MD
29c. License number: D52035
29d. Data signed (Month, Day, Year): Jan 16 2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): BINU CHACKO 291 STONER AV. Dixon Building Westminister MD 21157

State Registrar

31. Data filad (Month, Day, Year): JAN 17 2001
32. Registrar's Signatura: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00935

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE FRISS
2. Date of Death (Month, Day, Year): 01/15/2001
3. Time of Death: 11:16 AM
4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 156-12-1899
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 3, 1912
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: ☒1 Yes 2☐ No
10e. Street and Number: 6121 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HARRY MEDOFF
18. Mother's Name (First, Middle, Maiden Surname): REBECCA "UNAVAILABLE"

19a. Informant's Name/Reletionship (Type, Print): STEPHANIE KAY/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10964 BLOOMINGDALE DRIVE, ROCKVILLE, MARYLAND 20852

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): RODEF SHOLOM CEMETERY — Date: JAN 17, 2001
20c. Location - City or Town, State: ATLANTIC CITY, N.J.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CEREBRAL THROMBOSIS	1 WEEK
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. CEREBRAL ATHEROSCLEROSIS	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D18084
29d. Date signed (Month, Day, Year): JANUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

2001 JAN 17 AM 1:33

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00936

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SALLY ANNE FARIBAULT
2. Date of Death (Month, Day, Year): JANUARY 8 2001
3. Time of Death: 1038 AM
4a. Facility Name (If not institution, give street and number): MERCY MEDICAL CENTER HOSPICE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-22-4448
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 4, 1928
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 219 MAPLE AVENUE
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OFFICE MANAGER
16b. Kind of Business/Industry: BEVERAGE

17. Father's Name (First, Middle, Last): JOHN GREEN
18. Mother's Name (First, Middle, Maiden Surname): MARIE BENNETT

19a. Informant's Name/Relationship (Type, Print): MRS. EDITH CANBY (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 219 MAPLE AVENUE, GLEN BURNIE, MD. 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FORT SAM HOUSTON
Date: 1/12/2001
20c. Location - City or Town, State: SAN ANTONIO, TEXAS

21. Signature of Funeral Service Licensee: [signature] M01220
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Perinatal Abscess

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. ____

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease
Type II Diabetes.
Metastatic Lung Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) STELLA MARIS AT MERCY Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D40854
29d. Date signed (Month, Day, Year): JANUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE, MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00937

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARL PHILLIP FOGEL
2. Date of Death (Month, Day, Year): JANUARY 14, 2001
3. Time of Death: 11:50 AM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 072-22-8419
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 9, 1927
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: POTOMAC
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 11915 SEVEN LOCKS ROAD
10f. Zip Code: 20854
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1946-1947
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ATTORNEY
16b. Kind of Business/Industry: LAW

17. Father's Name (First, Middle, Last): SAMUEL FOGEL
18. Mother's Name (First, Middle, Maiden Surname): BETTY O'PALEK

19a. Informant's Name/Relationship (Type, Print): CAROL FOGEL/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11915 SEVEN LOCKS ROAD, POTOMAC, MARYLAND 20854

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEMORIAL GDSN | Date: JAN 16, 2001
20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b. Enterococcal Sepsis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.
29b. Signature and title of certifier: KR Lillie MD
29c. License number: D53244
29d. Date signed (Month, Day, Year): January 14, 2001
30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Carl Fogel January 14, 2001 11:50 AM

8 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00938

B. Walter

Forsythe Sr.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
WALTER	BREWER	FORSYTHE, SR.	January 14, 2001	6:10 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
North Arundel Hospital	Glen Burnie	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-24-7401	1 [X] M 2 [ ] F	72 Yrs.			JUNE 29, 1928	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	PASADENA	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1508 PARK LANE	21122	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		MACHINE OPERATOR	LANDFILL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WALTER FORSYTHE	ADA FORSYTHE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. EDITH FORSYTHE (WIFE)	1508 PARK LANE, PASADENA, MARYLAND 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	GLEN HAVEN MEMORIAL PARK	01/17/2001	GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary Artery Disease	
	Due to (or as a consequence of):	
	c. Chronic Obstructive Pulmonary Disease	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown	1 [ ] Yes 2 [✓] No	1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [✓] No	Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ George E. Wicks III M.D.	D41365	January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Wicks III M.D. 301 Hospital Drive, Glen Burnie, MD. 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ Donna G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00939

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie Frankton
2. Date of Death (Month, Day, Year): Jan. 13, 2001
3. Time of Death: 8:05PM
4a. Facility Name *(If not institution, give street and number)*: 1110 Linden Ave.
4b. City, Town, or Location of Death: Arbutus
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-12-3254
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 28, 1922
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1110 Linden Ave.
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Elmer Johnson
18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys Councilman

19a. Informant's Name/Relationship *(Type, Print)*: Susan Dolle, daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1110 Linden Ave. Arbutus, MD. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Good Sheppard Cemetery
Date: 1-17-01
20c. Location - City or Town, State: Ellicott City, MD

21. Signature of Funeral Service Licensee: Rebecca Rebissaw
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CANCER of Breast
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Metastatic Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Neil B. Knoppneh MD
29c. License number: D14753
29d. Date signed *(Month, Day, Year)*: 1/15/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 795 Aquahart Road, Glen Burnie, Maryland 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00940

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: Betty Mae Frentz

2. Date of Death Month 01- Dey 14- Year 01

3. Tima of Death: 12:30 P.M.

4a Facility Nama *(If not institution, give street and number)*: Franklin Woods Nursing Home

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Sacurity Number: 217-20-2926

6. Sex: 1☐M 2☒F

7. Aga *(In yrs. last birthday)*: 73 Yrs.

If Undar 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05-04-1927

9. Birthplece *(Stata or Foraign Country)*: Md.

Usual Rasidance of Decedant

10a. Stata: Md.

10b. County: Baltimore

10c. City, Town or Location: Edgemere

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2325 Lincoln Ave.

10f. Zip Coda: 21219

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐Yes 2☐No If Yas, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*

14. Rece - Americen Indien, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elementery/Secondery (0-12): 11; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Father's Nama *(First, Middle, Last)*: Elmer Creswell Mitchell

18. Mother's Nema *(First, Middle, Maidan Surnama)*: Minnie Mathias

19a. Informant's Name/Ralationship *(Type, Print)*: Linda Dillon / Daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 2325 Lincoln Ave., Edgemere, Md. 21219

20a. Mathod of Disposition: 1☐Burial 2☒Cremation 3☐Removal from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Place of Disposition *(Name of cematary, cramatory or othar place)*: Balto-Wash.Crematory Data: 1-16-01

20c. Location - City or Town, Stata: Laurel, Md.

21. Signatura of Funaral Service Licensaa ▶

22. Nama and Address of Facility: Bradley-Ashton-Matthews, Funeral Home, Inc 2134 Willow Spring Rd., Balto., MD. 21222

Physician /Medical Examiner

23a. Part1. Entar the diseasa, or complications that causad tha daath. Do not entar tha mode of dying, such as cardiac or raspiratory errast, shock, or heart failura. List only one ceuse on aach lina.

Approximata Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath): e. Liver cirrhosis — 3yrs.

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last:

b. Dua to (or as a consequance of):

c. Dua to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying causa givan in Part I.

23b. Did tobacco usa contributa to the cause of death? 1☐Yas 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☑No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was casa referred to medical examinar? 1☐Yas 2☑No

26. Plece of Daath *(Check only one)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA; Othar: 4☑Nursing Home 5☐Residence 8☐Othar *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, straat, factory, offica building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha tima, data and place, end dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, daath occurred at the time, data and place, and due to tha cause(s) and menner statad.

29b. Signature and titla of certifier ▶

29c. Licansa number: D44793

29d. Date signed *(Month, Day, Year)*: 1/15/01

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Dr. A. Sanai, M.D. 6730 Holabird Ave., Dundalk, Md. 21222

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signatura ▶ Grace G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

amend item 23a per md G791 1/17/01 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00941

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eric H. Givens

2. Date of Death: Month 01 Day 05 Year 2001

3. Time of Death: 1:00p.m.

4a. Facility Name (If not institution, give street and number): 4205 Bonner Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 220-86-4360

6. Sex: 1☒M 2☐F XX

7. Age (In yrs. last birthday): 29 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02 27 71

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No XX

10e. Street and Number: 4205 Bonner Road

10f. Zip Code: 21216

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced XX

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No X If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 3 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Manager

16b. Kind of Business/Industry: Balloon Orchard

17. Father's Name (First, Middle, Last): Donald Givens

18. Mother's Name (First, Middle, Maiden Surname): Zerita Singleton

19a. Informant's Name/Relationship (Type, Print): Zerita Singleton-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4205 Bonner Road, Baltimore Md 21216

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) X

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 1/11/01

20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Glynis B. Keke

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ~~Pneumonia~~ AIDS — 8 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald Bousel, MD

29c. License number: D36353

29d. Data signed (Month, Day, Year): 01/08/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Don Bousel 2411 W Belvedere Ave Baltimore MD 21215

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Deputy S Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00942

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELISE JACQUETTA GUY
2. Date of Death Month / Day / Year: JAN. 10 2001
3. Time of Death: 08:55AM
4a. Facility Name *(If not institution, give street and number)*: 319 EDGEWOOD STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-66-4566
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 31, 1956
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 319 EDGEWOOD STREET
10f. Zip Code: 21229
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CHILD CARE PROVIDER
16b. Kind of Business/Industry: SELF-EMPLOYED

17. Father's Name *(First, Middle, Last)*: JAMES PORTER
18. Mother's Name *(First, Middle, Maiden Surname)*: ANNIE CLARA WILLIAMS

19a. Informant's Name/Relationship *(Type, Print)*: LARRY GUY (HUSBAND)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 319 EDGEWOOD STREET BALTO. MD. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. ZION CEMETERY
Date: 01-16-01
20c. Location - City or Town, State: LANSDOWNE MARYLAND

21. Signature of Funeral Service Licensee: John Robbins
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Atrial Fibrillation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypercholesterolemia
CHF

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anthony Chestang M.D.
29c. License number: D00556578
29d. Date signed *(Month, Day, Year)*: 01/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anthony Chestang 2323 Orleans St. Balt. MD. 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Battimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00943

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
WOODROW M. GIBBS	JANUARY 11, 2001	7:00 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3110 WOLCOTT AVENUE	BALTIMORE	N/A

5. Social Security Number	6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
250-14-6886	1☒M 2☐F	78 Yrs.			APR. 26, 1922	N.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
M.D.	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3110 WOLCOTT AVENUE	21216	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		STEEL WORKER	BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
EDWARD GIBBS	MARY DAVIS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NANCY CARPENTER _ DAUGHTER	61 WEXFORD DR., Monmouth Junct. N.J. 08852

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Garrison Forest	01/19	Owings Mills, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ernest R. Tenney, Jr.	Nutter Funeral Homes, Inc 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PANCREATIC CA	5 mos
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiple myeloma

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Flavio Kruter MD	D35398	1-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Flavio Kruter M.D. 21 Crossroads Drive #415 Owings Mills MD 21117

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0221-510

SUSAN

GILES AMENDED ITEMS# 23& 27 per ME G793 030601 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00944

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
SUSAN	E.	GILES	JANUARY 13, 2001	9:48P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-17-1086	1☐ M 2☒ F	28 Yrs.			NOV. 25, 1972	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	CROWNSVILLE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1066 PLUM CREEK DRIVE	21032	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		TEACHER	PRIVATE SCHOOL

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)	
WILBUR	C.	GILES	JANET	DECKER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WILBUR C. GILES (FATHER)	1066 PLUM CREEK DRIVE, CROWNSVILLE, MD. 21032

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GLEN HAVEN MEMORIAL PARK	01/18/2001	GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PULMONARY HYPERTENSION	
	Due to (or as a consequence of):	
Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	O.C.M.E.	JANUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00945

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE GALEANO
2. Date of Death (Month, Day, Year): JANUARY 15 2001
3. Time of Death: 5:51 PM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-16-8406
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 17, 1922
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 804 Mildred Ave
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada complatad): Elementery/Secondary (0-12): 8 Yrs. | Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Nama (First, Middle, Last): Vincent Coleianne
18. Mother's Nama (First, Middle, Maiden Surnama): Angela Ditalia

19a. Informant's Name/Ralationship (Type, Print): Adele Conway Daughter
19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code): 426 Westfield Rd. Dundalk, Md. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, cremetory or other placa): Holy Redeemer Cem.
Data: Jan 18, 2001
20c. Location - City or Town, Stata: Dundalk, MD.

21. Signature of Funeral Service Licensee: Anthony C. Connelly
22. Nama and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on eech line.

Approximata Intervel Between Onset and Death

Immediata Causa (Final disease or condition resulting in daath)
a. SEPSIS
Due to (or as a consequence of):
b. PNEUMONIA

Sequentially iist conditions, if any, laading to immediate causa. Entar Underlying Cause (Disaasa or injury that initiated events rasulting in death) Last
Dua to (or as a consequanca of):
c. CANCER
Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.
MYOCARDIAL INFARCTION
GASTROINTESTINAL BLEED

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case rafarred to medical examiner? 1☐ Yas 2☒ No
26. Place of Daath (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and manner statad.
29b. Signature and title of certifier: MD
29c. Licansa number: 21000
29d. Date signed (Month, Day, Year): JANUARY 15, 2001
30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): MURTUZA AHMED. 4940 EASTERN AVENUE BALTIMORE MD 21224

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00946

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEO GRANT
2. Date of Death (Month, Day, Year): JAN 3 2001
3. Time of Death: 0736AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 088-48-1212
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 17, 1934
9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: Silver SPRING
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 8828 LANIER DR
10f. Zip Code: 20910
10g. Citizen of What Country? USA

11. Marital Status: unk — 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: unk
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk — College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Holy Cross Hospital
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1500 Forest Glen Road Silver Spring, MD 20902

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Chronic Obstructive Lung Disease	20 yrs.
Due to (or as a consequence of): b.	Respiratory failure	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tony P. Kannarkat MD
29c. License number: D20062
29d. Date signed (Month, Day, Year): JAN. 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TONY P. KANNARKAT MD 8201 - 16th ST Silver Spring MD 20910

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00947

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
FRANCES	GORDON	JANUARY 14, 2001	1:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LEVINDALE HEBREW HOME	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-20-5780	1☐ M 2☒ F	75 Yrs.			NOV. 30, 1925	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2434 W. BELVEDERE AVENUE	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
BENJAMIN	POLANSKY	SADIE	SEIDEL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MORRIS GORDON / HUSBAND	130 SLADE AVENUE #115 - BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BETH ISAAC ADATH ISRAEL	1/16/01	DUNDALK, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert [illegible]	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	1day
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Left CVA, HBP, Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Susan M. Levy MD	D33943	1/14/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan M. Levy MD Levindale

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00948

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARSHA GORDON
2. Date of Death Month Day Year: January 13, 2001
3. Time of Death: 12:48pm
4a. Facility Name *(If not institution, give street and number)*: UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-52-4757
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 23, 1949
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3656 MALDEN AVENUE
10f. Zip Code: 21211
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CUSTODIAN
16b. Kind of Business/Industry: CUSTODIAL ARTS

17. Father's Name *(First, Middle, Last)*: HERBERT GOLDMAN
18. Mother's Name *(First, Middle, Maiden Surname)*: ROSE DELLA VINCENT

19a. Informant's Name/Relationship *(Type, Print)*: JOSEPH GORDON / HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3656 MALDEN AVENUE - BALTIMORE, MD 21211

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEMETERY
Date: 1/15/01
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert failure. List only one cause on each fine.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)
a. cancer of unknown primary — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part ff. **Other significant conditiona** contributing to death but not resulting In the underlying cause given in Part f.: myocardial infarction

23b. Did tobacco use contributa to the cause of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K. Wilson MD
29c. License number: AT 243 89 46 19
29d. Date signed *(Month, Day, Year)*: January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen Wilson 201 East University Parkway Baltimore, MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00949

Patient known as: Gradman / Evelyn

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EVELYN GRADMAN
2. Date of Death Month Day Year: January 14, 2001
3. Time of Death: 11:45 pm
4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-16-1142
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN.21,1922
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6810 PARK HEIGHTS AVENUE #201
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 2 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: EXECUTIVE SECRETARY
16b. Kind of Business/Industry: FOOD

17. Father's Name *(First, Middle, Last)*: PHILIP GRADMAN
18. Mother's Name *(First, Middle, Maiden Surname)*: CECELIA KAPLIN

19a. Informant's Name/Relationship *(Type, Print)*: SYLVIA G. LEVINSON / SISTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7 SLADE AVENUE #822 - BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BALTIMORE HEBREW CEMETERY
Date: 1/16/01
20c. Location - City or Town, State: REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Terminal Aspiration — One Hour

Due to (or as a consequence of):
b. Non Small Cell Lung Cancer, Metastatic

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: RES-000
29d. Data signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcus McKenzie 2401 West Belvedere Baltimore, MD 2215

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

01-0209-510
B.K.S

ALEXANDER HENDERSON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00950

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alexander David Henderson-Broadway
2. Date of Death Month Day Year: JAN. 13, 2001
3. Time of Death: 0812 AM

4a. Facility Name *(If not institution, give street and number)*: UNIVERSITY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 375-08-9168
6. Sex: 1 XX M 2 ☐ F
7. Age *(In yrs. last birthday)*: 15 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 8, 1985
9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severn
10d. Inside City Limits: 1 ☐ Yes 2 XX No
10e. Street and Number: 1805 Chatfield Terrace
10f. Zip Code: 21144
10g. Citizen of What Country?: USA

11. Marital Status: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No *Specify:*
14. Rece - Americen Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student
16b. Kind of Business/Industry: N/A

17. Father's Nama *(First, Middle, Last)*: Harold David Henderson
18. Mother's Nama *(First, Middle, Maiden Surname)*: Barbara Broadway

19a. Informant's Name/Relationship *(Type, Print)*: Barbara J. Henderson (Mother)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1805 Chatfield Terrace, Severn, MD 21144

20a. Mathod of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cem.
Date: 01/22 2001
20c. Location - City or Town, Stete: Crownsville, MD

21. Signature of Funeral Service Licensee: Michelle D. Katta
22. Name and Address of Fecility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one causa on aach lina. — Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in deeth)
a. Multiple Gunshot Wounds
Due to (or as a consequance of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequance of):
d.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last

Part II. **Other significant conditfons** contributing to death but not resulting in the underlying ceuse givan in Part I.

23b. Did tobacco uas contributo to the cauas of death? 1 ☐ Yaa 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicel examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA / Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be datarmined
28a. Date of Injury *(Month, Day Year)*: 1-12-1
28b. Time of Injury: 2316 M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: suspect shot
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: street
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Jacobs Rd

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the causa(s) and manner stated.
29b. Signeture and title of certifier:
29c. License number: O.C.M.E
29d. Dete signed *(Month, Day, Year)*: JAN. 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00951

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Haynes
2. Date of Death: Month January Day 11 Year 2001
3. Time of Death: 2025
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: NA

Funeral Director

5. Social Security Number: 230-80-0225
6. Sex: 1☐M 2☐F XX
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-28-54
9. Birthplace (State or Foreign Country): SC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☐No XX
10e. Street and Number: 2921 S. Denham Circle
10f. Zip Code: 21225
10g. Citizen of What Country: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No XX If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐No XX Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction
16b. Kind of Business/Industry: Construction Co
17. Father's Name (First, Middle, Last): Ed Louis Haynes
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Benjamin
19a. Informant's Neme/Relationship (Type, Print): Vivian Haunes
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2921 S. Denham Circle Baltimore, Maryland 21225
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Gardens
Date: 01-17-2001
20c. Location - City or Town, State: Dundalk, MD
21. Signature of Funeral Service Licensee: ▶ Darnell L. Hunter
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E.North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	One Month
Due to (or as a consequence of): b.	Pneumonia	One Month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last — Due to (or es e consequence of): c.	Human Immunodeficiency Virus	Ten Years
Due to (or ea e consequence of): d.	End Stage Renal Disease	One Month

Part II. **Other stgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the causs of death? 1☐ Yes 2☒No 3☐ Probably 4☐ Unknown

24e. Was an eutopsy performed? 1☐ Yes 2☒No

24b. Were autopsy findings available prior to completion of causa ot death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yea 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Kazin, MD
29c. License number: RES-000
29d. Date aigned (Month, Day, Year): January, 11 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Rebecca Kazin, MD 600 N. Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

01-0194-510
jhm
MELVIN
HOPE amend item 23a,27,28a,b,c,d,ef per me G791 1/24/01 yf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00952

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN HOPE
2. Date of Death: Month JANUARY Day 12 Year 2001
3. Time of Death: 05:05 AM
4a. Facility Name (If not institution, give street and number): 1020 APPLETON STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-64-7232
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 43 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 17, 1957
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3630 PARK HEIGHTS AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENVIRONMENTAL SERVICES
16b. Kind of Business/Industry: UNIVERSITY OF MD.

17. Father's Name (First, Middle, Last): AUGUST HOPE
18. Mother's Name (First, Middle, Maiden Surname): ALBERTA JONES

19a. Informant's Name/Relationship (Type, Print): VALERIE HOPE (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3630 PARK HEIGHTS AVE. BALTO. MD. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. LUKES CEMETERY
Date: 01-18-01
20c. Location - City or Town, State: REISTERSTOWN, MD.

21. Signature of Funeral Service Licensee: Richard N. Miller
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day, Year): found 1/12/01
28b. Time of Injury: found 5:00 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): other residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3630 Park Heights Ave., Baltimore, Md

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Dye Kell
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARJORIE D. KELL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

FEB 2 2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #20B PER F.H. G791 1-18-01 WR.

Certificate of Death

Reg. No. 2001 00953

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS R. HOLLAND SR.

2. Data of Death (Month, Dey, Yaar): JANUARY 13, 2001

3. Time of Death: 11:15pm

4a. Facility Name *(If not institution, give street and number)*: GBMC GILCREST HOSPICE

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-56-4353

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Yaar)*: DEC. 19, 1951

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedant

10a. Stete: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yas 2 [ ] No

10a. Street and Number: 1216 W. LEXINGTON STREET

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SOLID WASTE

16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Name *(First, Middle, Last)*: REESE HOLLAND

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY CLAVON

19a. Intormant's Name/Reletionship *(Type, Print)*: NORMA J. HOLLAND (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1517 N. POTOMAC STREET BALTIMORE, MD 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: KING MEMORIAL PARK

Data: 1/20/01

20c. Location - City or Town, Stata: WOODLAWN, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. HEPATOCELLULAR CARCINOMA

Due to (or as a consequence of): b. CIRRHOSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last

Dua to (or as a consequence of): c. G-I BLEED

Dua to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the causa of death?** 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [ ] Residence 6 [X] Other *(Specify)* HOSPICE

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Yaar)*

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raymond A. Nzeng

29c. Licansa number: D34184

29d. Dete signed *(Month, Dey, Yaar)*: 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND A. NZEMO, 7801 YORK RD #100, TOWSON MD 21204

State Registrar

31. Date filed *(Month, Dey, Yaar)*: JAN 17 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00954

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Millard F. Herold Sr.

2. Date of Death (Month, Day, Year): January 12, 2001

3. Time of Death: 4 05 AM

4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF BEL AIR

4b. City, Town, or Location of Death: BEL AIR

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 217-03-2587

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): June 21 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Harford County

10c. City, Town or Location: Fallston

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2615 Lawson Road

10f. Zip Code: 21047

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Ice Man

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): William Herold

18. Mother's Name (First, Middle, Maiden Surname): Leona C. Gable

19a. Informant's Name/Relationship (Type, Print): Hilda M. Herold (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2615 Lawson Road Fallston, Md. 21047

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park | Date: 01/15/2001

20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: Richard Pickett

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebro Vascular Accident — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [✓] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 2 [ ] Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD

29c. License number: D32609

29d. Date signed (Month, Day, Year): 1/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kamnadius Muthani MD 1106 Revolution St Havre De Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

HERALD, MILLARD F.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 00955

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE I. HOLLINS
2. Date of Death (Month, Day, Year): JANUARY 12 2001
3. Time of Death: 3:50 PM
4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF NORTH ARUNDEL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 219-30-4310
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 30 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5 E. Ostend Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker
16b. Kind of Business/Industry: Perfume Factory

17. Father's Neme (First, Middle, Last): Jess Charles Detress
18. Mother's Name (First, Middle, Meiden Sumeme): Anna Schultz

19a. Informent's Neme/Reletionship (Type, Print): Joann Adams (Daughter)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4221 Grace Court, Baltimore, Md. 21226

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): Cedar Hill Cemetery
Date: 01/16/2001
20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: Kevin E. Ecker
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, auch es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Renal Cell Carcinoma	1 year
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest	b.	
Due to (or as a consequenca of):		
	c.	
Due to (or es a consequenca of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or Investigetion, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Jasi M.D
29c. License number: D54292
29d. Date signed (Month, Day, Year): 1/15/2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): SUICHPAL JASSI, 1600 CRAIN HIGHWAY SUITE 201, GLEN BURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrer's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00956

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kathleen Denise Harris

2. Date of Death Month / Day / Year: January 15 2001

3. Time of Death: 8:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: 5650 Harbor Valley Drive

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213 64 4234

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 36 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 28, 1964

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5650 Harbor Valley Drive

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+)

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Asst. Treasurer/Secretary

16b. Kind of Business/Industry: Mercantile Bank

17. Father's Name *(First, Middle, Last)*: Ernest Heyliger

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Lane

19a. Informant's Name/Relationship *(Type, Print)*: Scott Harris / Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5650 Harbor Valley Drive Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery

Date: 1/18/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Jerome Francomacho

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death)

a. BRAIN TUMOR — 12 Mos

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Barry Meisenberg

29c. License number: 051260

29d. Date signed *(Month, Day, Year)*: JAN 16 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRY MEISENBERG UNIV. OF MD CANCER CTR 22 S Greene St BALTIMORE MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00957

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen J. Hollingsworth
2. Data of Death — Month: January Day: 9 Year: 2001
3. Time of Death: 10:30A.M.
4a Facility Name *(If not institution, give street and number)*: Genesis Elder Care Perring Parkway
4b. City, Town, or Location of Death: Hillendale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-16-5118
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 11/05/1921
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 35 Portship RD
10f. Zip Code: 21222
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Homemaker
16b. Kind of Businass/Industry: Own Home

17. Father's Nama *(First, Middle, Last)*: Joseph Vrablic
18. Mothar's Name *(First, Middle, Maiden Surnama)*: Helen Osusky

19a. Informant's Name/Relationship *(Type, Print)*: Mary Klima Daughter
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 14 Chapel Manor Road Perry Hall, MD 21128

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* Entombment
20b. Place of Disposition *(Nama of cemetary, crematory or othar place)*: Oaklawn Cemetery — Data: 01/12/01
20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee ▶
22. Nama and Addrass of Facility: Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring RD BAltimore, MD 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such es cardiac or raspiretory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onsat and Death
Immediata Causa (Final disease or condition resulting in death) a.	Myocardial Infarction	days
Dua to (or as a consequence of): b.	ASCVD (Coronary artery Disease)	years
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Dua to (or as a consequence of): c.		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHF Pneumonia Sepsis ASCVD COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yas 2☑ No

24b. Ware autopsy findings evallable prior to completion of ceuse of deeth? 1☐ Yas 2☑ No

25. Wes case refarred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the tima, date end placa, and due to tha cause(s) and mannar steted.

29b. Signature and title of certifier ▶ Martha C. Neumunds MD
29c. License number: 054518
29d. Data signed *(Month, Day, Year)*: 1/9/1

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)- 3007 E. Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature ▶ Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00958

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christopher James

2. Date of Death: Month: January Day: 9 Year: 2001

3. Time of Death: 1505

4a. Facility Name (If not institution, give street and number): Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 239-48-8741

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04 17 33

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 5147 Frederick Ave

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade | College (1-4or 5+): na

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Sheet Metal Worker

16b. Kind of Business/Industry: Bethlehem Steel Corp

17. Father's Name (First, Middle, Last): Martin James

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informent's Neme/Relationship (Type, Print): Deborah L. Ward-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3629 Valley Terr. Apt. 2 Baltimore Md 21244

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Arbutus Memorial Park

Date: 1/17/01

20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: ▶ Willie Edmonds

22. Nama and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disaasa or condition resulting in death)

a. Adult respiratory distress syndrome — one week

Due to (or as a consequence of):

b. Sepsis — one week

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Thermal injury — fourteen days

Due to (or as a consequence of):

d.

Theodore McKim, M.D. CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Piece of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Mannar of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): December 26 2000

28b. Time of Injury: 0441 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Housefire

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 5147 Frederick Avenue Baltimore, Maryland

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: ▶ [signature], MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): January 11, 2001

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Jeffrey Schreiber 4940 Eastern Avenue Baltimore, Maryland 21224

State Registrar

31. Dete filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00959

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald R. Jones
2. Date of Death: Month January Day 11 Year 2001
3. Time of Death: 1150
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-30-7296
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/14/36
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PERRY HALL
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8622 MANORFIELD ROAD
10f. Zip Code: 21236
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1956-76
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAINTENANCE SUPERVISOR
16b. Kind of Business/Industry: BALTO. CO. SCHOOLS

17. Father's Name (First, Middle, Last): WILLIAM JONES
18. Mother's Name (First, Middle, Maiden Surname): AUGUSTA NAUMANN

19a. Interment's Name/Relationship (Type, Print): MR. JOHN JONES
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3761 FOXFORD STREAM RD. BALTO., MD. 21236

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART OF JESUS
Date: 1/15/01
20c. Location - City or Town, State: DUNDALK, MD.

21. Signature of Funeral Service Licensee: Charles Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ADULT RESPIRATORY DISTRESS SYNDROME — 5 Days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
EMPHYSEMA
LUNG CANCER

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Resident
29c. License number: RES-000
29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANOJ MALOO The JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00960

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Mae Jackson
2. Date of Death (Month, Day, Year): Jan. 3, 2001
3. Time of Death: 5:45p.m.
4a. Facility Name *(If not institution, give street and number)*: BROOK GROVE NURSING HOME
4b. City, Town, or Location of Death: Sandy Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 228-72-0273
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 24, 1909
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Sandy Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 18100 Slade School Road
10f. Zip Code: 20860
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Bertram Champion Gough
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Minnie Alma Edwards

19a. Informant's Name/Reletionship *(Type, Print)*: Nancy Teimourian Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11001 Cripplegate Road, Potomac, MD 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Park National Memoroal — Date: 01/06
20c. Location - City or Town, State: Falls Church VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: National Funeral Home 7482 Lee Highway, Falls Church, VA 22042

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approxtmate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	CACHEXIA AND DEHYDRATION	WEEKS
Due to (or as a consequence of):		
b.	DYSPHAGIA	WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	ADVANCED SENILE DEMENTIA	YEARS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: [signature] J E Howe MD
29c. License number: D33700
29d. Date signed *(Month, Day, Year)*: JANWARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED E. HOWE 154 N. ARTIZAN STREET, WILLIAMSPORT, MD. 21795

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00961

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Jansky
2. Date of Death (Month, Day, Year): January 13 2001
3. Time of Death: 1035 PM
4a. Facility Name (If not institution, give street and number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-22-4995
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-30-27
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 326 Wye Road
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Operator
16b. Kind of Business/Industry: Mercy Medical Center

17. Father's Name (First, Middle, Last): Henry Hupfer
18. Mother's Name (First, Middle, Maiden Surname): Marie Whitfield

19a. Informant's Name/Relationship (Type, Print): Jerome Jansky/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 326 Wye Road Baltimore, MD 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cem
Date: 1-17-01
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue, Baltimore, MD 21237

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Recurrent aspiration pneumonia — 5 weeks
Due to (or as a consequence of):
b. Esophageal carcinoma — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
pericardial effusion
pleural effusions
history of breast cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gary B. Ruppert
29c. License number: D18446
29d. Date signed (Month, Day, Year): January 14, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GARY B. RUPPERT, MD 301 St. Paul Place #411 Balto. MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

ADH
DOREEN JOHNSON
01-0136-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G791 1-30-01 WR. *Certificate of Death*

Reg. No 2001 00962

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOREEN Johnson
2. Date of Death Month Day Year: JANUARY 8, 2001
3. Time of Death: 1619 PM
4a. Facility Name (If not institution, give street and number): BAYVIEW HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 219-70-0248
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 41 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/10/1959
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 4028 South Claire St.
10f. Zip Code: 21213
10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: G. C. Murphy

17. Father's Name (First, Middle, Last): James Johnson
18. Mother's Name (First, Middle, Maiden Surname): Doris Jenkins

19a. Informant's Name/Relationship (Type, Print): Shirley Eldridge-Aunt
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1718 N. Wolf 21213 Baltimore, Maryland

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 1/15/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Shirley Miller
22. Name and Address of Facility: Miller's Metropolitan Chapel PA 1639 N. Broadway Balto. MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC ALCOHOLISM

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Katsenelinboigen
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Usher Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Donna S Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00963

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen B. Kirby
2. Date of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 5:06 AM
4a. Facility Name *(If not institution, give street and number)*: 2201 Woodbine Road
4b. City, Town, or Location of Death: Woodbine
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-07-1625
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 22, 1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5125 Viaduct Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper
16b. Kind of Business/Industry: Trucking Company

17. Father's Name *(First, Middle, Last)*: Irvin Barnett
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Keck

19a. Informant's Name/Relationship *(Type, Print)*: George W. Kirby, Jr./Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8408 Lockwood Road Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Woodlawn Cemetery
Date: 1/16/01
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: ▶ Juanita R Thomas
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Large Malignant Brain Tumor
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)* Daughter's
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ C.T. Solomon MD, FACS
29c. License number: D0037668
29d. Data signed *(Month, Day, Year)*: 01/15/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CLIFFORD T Solomon MD 600 Ridgely Ave Ste 225 Annapolis MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: ▶ Donna G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00964

KLEIN, CHARLES

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Benjamin Klein

2. Date of Death — Month: JANUARY Day: 10 Year: 2001

3. Time of Death: 9:48 P.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-12-6767

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 30, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6637 Walther Avenue

10f. Zip Code: 21206

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondery (0-12): 8th. Grade; College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Chauffeur

16b. Kind of Business/Industry: Limousine Company

17. Father's Neme (First, Middle, Last): George Klein

18. Mother's Neme (First, Middle, Maiden Surneme): Helen Mann

19a. Informent's Neme/Reletionship (Type, Print): Virginia Klein / Wife

19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6637 Walther Avenue Baltimore MD 21206

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Moreland Memorial Park

Dete: 01/15/2001

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee:

22. Neme end Address of Fecility: John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206

Physician /Medical Examiner

23a. Pert1. Enter the diseases or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert teilure. Enter only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

a. AORTIC STENOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

SEPSIS, CHRONIC RENAL FAILURE, CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one) — Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and mennar as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Babak Imanoel MD

29c. License number: BI6283472

29d. Date signed (Month, Dey, Year): 1/11/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): BABAK IMANOEL, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Dey, Year): JAN 17 2001

32. Registrer's Signature: G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

01-0235-005
CJ
Keith Kraska
amend item 23a,27,28a,b,c,d,e,f fper me G791 1/24/01yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00965

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Keith B. Kraska
2. Date of Death: Month: January Day: 14 Year: 2001
3. Time of Death: 09:33 A.M.
4a. Facility Name (If not institution, give street and number): 2039 Larkhall Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-90-6982
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 38 Yrs. If Under 1 Yaer: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 8, 1962
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Dacedant

10a. Steta: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 2039 Larkhall Road
10f. Zip Coda: 21222
10g. Citizen of What Country?: United States
11. Meritel Stetus: 1 [X] Nevar Married 2 [ ] Married 3 [ ] Widowad 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yas, Giva Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yea or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, White, atc. Specify: White
15. Decedent's Education (Specify only highest grade compiated): Elementary/Secondery (0-12): 10 Years; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona duning most of working lifa. DO NOT use ratired): Machine Operator
16b. Kind of Business/Industry: Manufacturing
17. Father's Name (First, Middle, Last): Walter Kraska, Sr.
18. Mother's Nama (First, Middle, Meiden Sumama): Eleanor Acuri
19a. Intormant's Name/Ralationship (Type, Print): Eleanor Kraska (Mother)
19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 2039 Larkhall Road Dundalk, Maryland 21222
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of cematary, crematory or othar place): Holly Hill Mem. Gdns.
Data: 1/18/2001
20c. Location - City or Town, Steta: Middle River, MD
21. Signature of Funaral Service Licensee: [signature]
22. Nama and Addrass of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the daath. Do not antar the mode of dying, such as cardiac or raspiretory arrast, shock, or heart failura. List only ona causa on aach line.

Approximata Interval Batween Onset and Death

Immediata Causa (Final diseasa or condition resulting in daath): a. NARCOTIC INTOXICATION

Dua to (or es e consequence of):

Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Causa (Diseasa or injury that initiated events resulting in death) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa raferred to medical examinar? 1 [X] Yas 2 [ ] No

26. Placa of Death (Check only one): Hospitel: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [ ] Rasidence 8 [X] Othar (Specify) Scene unknown

27. Mannar of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Dete of Injury (Month, Day Year) found: 1/14/01

28b. Time of Injury found: 9:15 A M

28c. Injury at Work? 1 [ ] Yas 2 [X] No

28d. Describe how injury occurred: unknown

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence

28f. Location (Street and Number or Rural Routa Number, City or Town, State): 2039 Larkhall Rd., Baltimore, MD.

29a. Certifiar (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. 2 [X] **Medical Examiner**: On tha basis of axamination and/or invastigetion, in my opinion, deeth occurred at tha time, data and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature] M.E.

29c. License number: O.C.M.E.

29d. Data signed (Month, Day, Year): January 15, 2001

30. Nama and address of person who compiated causa of daath (Item 23a) (Type, Print): M.D. Physicians A. Korell 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 5 per fh G792 2/7/01 yf
amend item 1 per md G792 2/7/01 yf

Certificate of Death

Reg. No. 2001 00966

KOLLENBERG Lee C.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lee C. Kollenberg ~~Lena C. Kollenberg~~

2. Date of Death (Month, Day, Year): JANUARY 10, 2001

3. Time of Death: 8:09PM

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 563-40-9856 ~~569-01-1816~~

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 108 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 9, 1892

9. Birthplace (State or Foreign Country): Connecticut

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Odenton

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 1194 Wiener Road

10f. Zip Code: 21113

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mender

16b. Kind of Business/Industry: Hosiery

17. Father's Name (First, Middle, Last): Charles Spenetti

18. Mother's Name (First, Middle, Maiden Surname): Pauline Unknown

19a. Informant's Name/Relationship (Type, Print): Robert Boydstun (Son-in-law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1194 Wiener Road, Odenton, MD 21113

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Our Lady of the Fields

Date: 01/12 2001

20c. Location - City or Town, State: Millersville, MD

21. Signature of Funeral Service Licensee: Michael P. Kutta

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease — 8 years

Due to (or as a consequence of):

c. Essential Hypertension — 30 years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Harjit Singh M.D.

29c. License number: D0014160

29d. Date signed (Month, Day, Year): 01/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Geneva B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#1perPHY,18 perFHG791 1/25/2001 EW

Certificate of Death

Reg. No. 2001 00967

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~SANAH~~ Sanah ~~KAZI~~ Tehseen Kazi

2. Date of Death (Month, Day, Year): JAN 16 2001

3. Time of Death: 1445

4a. Facility Name (If not institution, give street and number): 8704 AIRYBRINK LN. APT. 301

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 216-53-3367

6. Sex: 1☐ M XX F

7. Age (In yrs. last birthday): 9 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09 02 91

9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8704 Airybrink Lane #301

10f. Zip Code: 21045

10g. Citizen of What Country? India

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: Indian

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 4th grade

College (1-4or 5+): na

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Riyaz Kazi

18. Mother's Name (First, Middle, Maiden Surname): Najma ~~Shaikh~~ Shaikh

19a. Informant's Name/Relationship (Type, Print): Riyaz Kazi-Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8704 Airybrink Lane #301, Columbia Md 21045

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 01/17/01

20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Darnell K. Hunter

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. SUBUNCAL (BRAIN) HERNIATION — ONE HOUR

Due to (or as a consequence of):

b. GLIOBLASTOMA MULTIFORME — 13 MONTHS

Sequentially list conditions, If any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uaa contribute to tha causa of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Yu Wayne Chu

29c. License number: RES-000

29d. Date signed (Month, Day, Year): 1/17/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): YU-WAYNE CHU, M.D. PEDIATRIC ONCOLOGY, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD 600 N. WOLFE ST. 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00968

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen V. Kwiatkowski
2. Date of Death — Month: January; Day: 16; Year: 2001
3. Time of Death: 2:15 A.M.
4a. Facility Name *(If not institution, give street and number)*: Chesapeake Hospice House
4b. City, Town, or Location of Death: Linthicum
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214 03 7894
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 6, 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Linthicum
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 303 Jerome Avenue
10f. Zip Code: 21090
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - American indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator
16b. Kind of Business/Industry: Necktie Company

17. Father's Name *(First, Middle, Last)*: Michael Arendt
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Janowski

19a. Informant's Name/Relationship *(Type, Print)*: Bernard Kwiatkowski / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 303 Jerome Avenue Linthicum, Maryland 21090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: St. Stanislaus Cemetery
Date: 1/19/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Jerome Gronouski
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ischemic cardiomyopathy
Due to (or as a consequenca of):
b. Chronic Atrial Fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Edward Kenna MD
29c. Licensa number: D19171
29d. Data signed *(Month, Day, Year)*: 1-16-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 795 Aycabar Road Glen Burnie, Maryland 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: ▶ Geneva G Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00969

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charlotte Dominica Kraft

2. Date of Death (Month, Day, Year): Jan. 13, 2001

3. Time of Death: 3:00AM

4a. Facility Name *(If not institution, give street and number)*: Forest Haven Nursing Home

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-20-7037

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 25, 1925

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore Highlands

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 3021 Georgia Ave.

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Robert Fitzberger

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Hughes

19a. Informant's Name/Relationship *(Type, Print)*: Cathy Piller, daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3021 Georgia Ave. Baltimore Highlands, MD. 21227

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: 1-15-01

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Rebecca Fabritius

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimers disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: recurrent pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D37573

29d. Date signed *(Month, Day, Year)*: January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Tibell MD 25 Main Street Reisterstown MD 21136

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#5 PER F.H. G791 1-31-2001 JAB

Certificate of Death

Reg. No. 2001 00970

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month	Day	Year	3. Time of Death
Sophia	Karamanlidis	January	10,	2001	10:30pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4204 Garland Ave.	Perry Hall	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~198-44-0466~~ 198-44-0446	1☐ M 2☒ F	72 Yrs.			11-18-1928	Greece

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Perry Hall	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4204 Garland Ave.	21236	United States

11. Meritel Stetus	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Rece - American Indien, Bleck, White, etc.
1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Give Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Educetion (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
1 Year	-------	Seamstress	Textile

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middle, Maidan Surnama)
Anastasios Lazaridis	Elisavet Toutougia

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Kyriakos Karamanlidis (son)	4204 Garland Ave. Perry Hall, MD 21236

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cemetary, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)	Oaklawn Cemetery	1-13	Baltimore, MD

21. Signeture of Funeral Service Licensee ▶

22. Nama and Addrass of Facility: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd. Balt. MD 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one causa on aach lina.

Approximata Intarval Batween Onset and Daath

Immediata Causa (Finel disaasa or condition rasulting in daath)

a. Metastatic Breast Cancer.

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐ Yas 2☒ No	1☐ Yes 2☐ No

25. Was casa rafarred to medical axaminar?	26. Placa of Death (Check only ona)	
1☐ Yas 2☒ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☒ Residence 6☐ Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to the cause(s) and mannar stated.

29b. Signeture and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶	D18320	1/12/01

30. Nama and addrass of person who completed ceusa of death (Item 23a) (Type, Print): John Fetting M.D. 10753 Falls Rd. Lutherville MD 21093

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ Janice G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00971

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melkon M Koroukian
2. Date of Death (Month, Day, Year): January 12 2001
3. Time of Death: 0842
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-92-0647
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs, last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 15, 1921
9. Birthplace (State or Foreign Country): Adana, Turkey

Usual Residence of Decadent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 303 Meadowcroft Lane
10f. Zip Code: 21093
10g. Citizen of Whet Country?: Lebanon

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Designer
16b. Kind of Business/Industry: Self-employed

17. Father's Name (First, Middle, Last): Mikael Koroukian
18. Mother's Name (First, Middle, Maiden Surname): Siroun Mangoyan

19a. Informent's Name/Relationship (Type, Print): Kenarik M. Koroukian
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 303 Meadowcroft Lane, Lutherville, MD 21093

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gdns
Date: Jan. 16 2001
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Brian T.
22. Name and Address of Facility: Chisholm Funeral Services of Dulaney Valley, P.A. 200 E. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or compiications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ATHEROSCLEROTIC CORONARY ARTERY DISEASE	13 years
Due to (or as a consequence of): b.	ISCHEMIC CARDIOMYOPATHY	13 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last — Due to (or as a consequence of): c.	UREMIA	6 MONTHS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elias Ghandour MD
29c. License number: D0035706
29d. Date signed (Month, Day, Year): January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELIAS GHANDOUR GOOD SAMARITAN HOSP. BALT. MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificata be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00972

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Kusher
2. Date of Death (Month, Day, Year): January 15 2001
3. Time of Death: 7:45 AM

4a. Facility Name (If not institution, give street and number): GENESIS LONGGREEN NURSING
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 085-01-4107
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 1, 1909
9. Birthplace (State or Foreign Country): RUSSIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKTON
10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17 BUSH CABIN COURT
10f. Zip Code: 21120
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKKEEPING
16b. Kind of Business/Industry: INSULATION CO.

17. Father's Name (First, Middle, Last): BERKO FRIEDMAN
18. Mother's Name (First, Middle, Maiden Surname): ROSE SAFASMAN

19a. Informant's Name/Relationship (Type, Print): BARBARA KAHAN / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 BUSH CABIN COURT - PARKTON, MD 21120

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HILLTOP SERVICE CORP.
Date: 1/16/01
20c. Location - City or Town, State: TOWSON, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Silent Arrhythmia — Minutes

Due to (or as a consequence of):
b. Arteriosclerotic Coronary Artery Disease — Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Stroke, peripheral Vascular Disease, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D17118
29d. Date signed (Month, Day, Year): Jan 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartzman 115 E. Melrose 21212

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0147-510

CHARLES KAISER

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00973

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Michael Kaiser

2. Date of Death (Month, Day, Year): JANUARY 09 2001

3. Time of Death: 12:30 P

4a. Facility Name (If not institution, give street and number): 4404 WHITE AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 219-03-0787

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3/24/1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 4404 White Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: Steel Company

17. Father's Name (First, Middle, Last): Victor J. Kaiser

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Kubicka

19a. Informant's Name/Relationship (Type, Print): Anna Jaworski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 333 Ida Avenue Baltimore, Maryland 21221

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery

Date: 1/13/00

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intra-Oral Gunshot Wound

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cancer of Colon and Liver

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): Found 1-9-01

28b. Time of Injury: Found 12:10 p M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: self-inflicted gunshot wound

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4408 White Ave Baltimore, MD

29a. Certifier (Check only one): 1☐**Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Chutes

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JANUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutes 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature:

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00974

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dolores Diane Liberto
2. Date of Death: Month Jan, Day 14, Year 2001
3. Time of Death: 10:55 AM
4a. Facility Name (If not institution, give street and number): Atlantic General Hospital
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 215-34-8098
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Dec 24, 1936
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Bishopville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13285 Rollie Road East
10f. Zip Code: 21813
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Harvey Whittington
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Taylor

19a. Informant's Name/Reletionship (Type, Print): Joseph Liberto, Jr. / husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13285 Rollie Road East, Bishopville, Maryland 21813

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 1/18/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Metastatic Breast Cancer	4 YEARS
Due to (or as a consequence of):		
b.	Coronary Artery Disease	4 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0047676
29d. Date signed (Month, Day, Year): 1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BSHOR TOULOUMAT 9733 Heathway Dr BERLIN MD 21811

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Joanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Liberto, Dolores D 215 34 8098 DOB 12/24/36 1/4/01 10:55 AM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00975

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Y. Lumpkin
2. Date of Death: Month January Day 13 Year 2001
3. Time of Death: 8:45AM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-24-3597
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-29-1911
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Bowleys Quarters
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3935 New Section Road
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In own Home

17. Father's Name (First, Middle, Last): Alfredo Garrassi
18. Mother's Name (First, Middle, Maiden Surname): Vincenzina Manna

19a. Informant's Name/Relationship (Type, Print): daughter Pat Lumpkin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3935 New Section Rd., Baltimore, Maryland 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer
Date: 1/16/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Marcia M. Zannino
22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Hm 263 South Conkling St. Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	1 week
Due to (or as a consequence of):	b. Pneumonia	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eldadah MD Physician
29c. License number: D0054303
29d. Date signed (Month, Day, Year): January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Eldadah 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Lorraine G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Lumpkin, Mary
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00976

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RALPH WOODROW LANE
2. Date of Death (Month, Day, Year): JANUARY 13, 2001
3. Time of Death: 1250 AM
4a. Facility Name (If not institution, give street and number): STELLA MARIS (MERCY) HOSPICE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-70-3584
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 09, 1959
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2515 NORTH ROSEDALE ST.
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSTRUCTION WORKER
16b. Kind of Business/Industry: CONSTRUCTION COMPANY

17. Father's Name (First, Middle, Last): CLYBURN LANE SR.
18. Mother's Name (First, Middle, Maiden Surname): DAISY GUNTHER

19a. Informant's Name/Relationship (Type, Print): SYLVIA DARDEN (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2515 N. ROSEDALE ST, BALTO, MD. 21216

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 01-17-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acquired Immunodeficiency Syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify): STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D40854
29d. Date signed (Month, Day, Year): JANUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE, MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature] Spark

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00977

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frank E. Locklear
2. Date of Death (Month / Day / Year): January 14 2001
3. Time of Death: 4:15 P.M.

4a. Facility Name *(If not institution, give street and number)*: 5226 - 6th Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 239 42 0003
8. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 31, 1928
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5226 - 6th Street
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tow Truck Driver
16b. Kind of Business/Industry: City of Baltimore

17. Father's Name *(First, Middle, Last)*: Gus Howard Locklear
18. Mother's Name *(First, Middle, Meiden Sumeme)*: Penelope Hunt

19a. Informant's Name/Relationship *(Type, Print)*: Wanda Brown / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7124 Garden View Court Baltimore, Maryland 21226

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery
Date: 1/18/01
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licansee: Jerome Gronmarker
22. Name and Address ol Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Multiple Cerebrovascular	11/1/00
Due to (or as a consequence of): b.	Initial Accidente Stroke	1980
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequenca ol): c.	Hypertension	1980
Due to (or as e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease; Hyponatremia

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residenca 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time ol Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end placa, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D31744
29d. Date signed *(Month, Day, Year)*: 1/15/2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. George Hebard 4710 Pennington Avenue Baltimore, Maryland 21226

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00978

Lillian Lotz

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Lillian Anna Lotz							2. Date of Death (Month, Day, Year): JANUARY 14 2001		3. Time of Death: 945PM
4a. Facility Name (If not institution, give street and number): North Arundel Hospital				4b. City, Town, or Location of Death: Glen Burnie			4c. County of Death: Anne Arundel		
5. Social Security Number: 215 34 8745	6. Sex: 1☐M 2☒F	7. Age (In yrs. last birthday): 63 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.			8. Date of Birth (Month, Day, Year): August 23, 1937		9. Birthplace (State or Foreign Country): Maryland
Usual Residence of Decedent									
10a. State: Maryland	10b. County: Anne Arundel	10c. City, Town or Location: Pasadena							10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 7808 Outing Avenue			10f. Zip Code: 21122				10g. Citizen of What Country?: U.S.		
11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:					14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th / College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Care taker					16b. Kind of Business/Industry: Day care		
17. Father's Name (First, Middle, Last): John Balling							18. Mother's Name (First, Middle, Maiden Surname): Anna Kotchen		
19a. Informant's Name/Relationship (Type, Print): Francis J. Lotz / Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7808 Outing Avenue Pasadena, Maryland 21122							
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park					Date: 1/18/01	20c. Location - City or Town, State: Glen Burnie, Maryland	
21. Signature of Funeral Service Licensee: George J. Gonce		22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225							

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD | 29c. License number: D51245 | 29d. Date signed (Month, Day, Year): JANUARY, 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAJID SHARIF NORTH ARUNDEL HOSPITAL - 301 Hospital Drive - GLEN BURNIE MD 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Annie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00979

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HUNG BONG LEE

2. Date of Death (Month, Day, Year): January 11 2001

3. Time of Death: 4:35 P.M.

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL ASSOCIATION

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-92-5840

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 13, 1906

9. Birthplace *(State or Foreign Country)*: KOREA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: SEVERNA PARK

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 658 FAIRCASTLE AVENUE

10f. Zip Code: 21146

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No. If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* ASIAN

15. Decedent's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 8 | Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: BO IN LEE

18. Mother's Name *(First, Middle, Maiden Surname)*: (UNKNOWN) (UNKNOWN)

19a. Informant's Name/Raiationship *(Type, Print)*: MR. SUN LEE (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 658 FAIRCASTLE AVENUE, SEVERNA PARK, MD. 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, cremetory or other piece)*: OAK LAWN CEMETERY

Date: 1/15/2001

20c. Location - City or Town, Stete: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: M01220

22. Nama and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the daath. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only one ceuse on eech line. — Approximate Intervel Batween Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death): e. SEPTICEMIA

Dua to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immedieta cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. ASPIRATION PNEUMONIA.

Due to (or es e consequance of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the causes of death? 1☐ Yas 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availabla prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes casa raferred to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datermined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the tima, data and place, and dua to tha causa(s) and manner stated.

29b. Signatura and titia of certifiar: MD

29c. Licanse number: D43977

29d. Date signed *(Month, Day, Year)*: January 11 2001

30. Neme and address of person who completed ceusa of daath (Item 23a) (Type, Print): Ayoken Onejunji 301 Hospital Drive, Glen Burnie, MD. 21061

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 17 2001

32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

HUNG LEE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00980

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alonzo A. Lewis

2. Data of Death — Month: January Day: 13 Year: 2001

3. Time of Death: 7:00A.M.

4a. Facility Name (If not institution, give street and number): 903 Forwood Court

4b. City, Town, or Location of Death: Dundalk

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-16-7358

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08/28/1923

9. Birthplace (State or Foraign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 903 Forwood Court

10f. Zip Code: 21222

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Nevar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☒ Yas 2 ☐ No — If Yes, Give Yaar or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middla, Last): John T. Lewis

18. Mother's Neme (First, Middle, Meiden Surname): Pearl Battee

19a. Informant's Name/Reletionship (Type, Print): Frances Lewis Wife

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 903 Forwood CT Baltimore, MD 21222

20a. Mathod of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): Balto-Wash Crematory — Date: 01/17/01

20c. Location - City or Town, Stata: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ Robert Radle

22. Name and Addrass of Facility: Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring Baltimore, MD 21222

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused tha death. Do not enter the mode ot dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease — Years

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as e consequenca of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(e) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: 041614

29d. Date signed (Month, Day, Year): January 16, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Alan Falk 4920 Campbell Blvd White Marsh, MD. 21236

State Registrar

31. Dete filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00981

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
ETHEL	LEVINE	JANUARY 13, 2001	9:40 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MILFORD MANOR NURSING HOME	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-24-5328	1☐ M 2☒ F	91 Yrs.			NOV. 21, 1909	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4204 OLD MILFORD MILL ROAD	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		HOUSEWIFE	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
MORRIS	GLASER	EMMA	(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
FRANCES SCHWARTZ / DAUGHTER	11 SLADE AVENUE #705 - BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HEBREW FRIENDSHIP CEMETERY	1/15/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M. Mann M.D.	D42561	1/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Martin Passen, M.D. 21 Crossroads Dr #400 Owings Mills, MD 21117

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00982

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucy Helen Lynch

2. Date of Death: Month January Day 8 Year 2001

3. Time of Death: 1:25 A.M.

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 120-32-4778

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03/07/1906

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Fulton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9448 Lovat RD

10f. Zip Code: 20759

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher

16b. Kind of Business/Industry: Pearson School

17. Father's Name (First, Middle, Last): Michael Lynch

18. Mother's Name (First, Middle, Maiden Surname): Catherine Gorman

19a. Informent's Name/Relationship (Type, Print): Catherine C. McMahon Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9448 Lovat RD Fulton, MD 20759

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sleepy Hollow Cemetery | Date: 01/11/01

20c. Location - City or Town, State: Sleepy Hollow, NY

21. Signature of Funeral Service Licensee: Stephanie Alli

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. BAltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DEMENTIA — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ZOSTER DERMATITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Matthew J. Norris M.D.

29c. License number: D44748

29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW J NORRIS M.D.

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00983

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RIFKA LINDENBLATT

2. Date of Death (Month, Day, Year): JAN 13 2001

3. Time of Death: 5:50AM

4a. Facility Name *(If not institution, give street and number)*: MILFORD MANOR NURSING HOME

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 056-26-0755

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAR 15 1908

9. Birthplace *(State or Foreign Country)*: POLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6809 BROOKMILL ROAD

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SEAMSTRESS

16b. Kind of Business/Industry: SELF-EMPLOYED

17. Father's Name *(First, Middle, Last)*: ENOCH LEIKACH

18. Mother's Name *(First, Middle, Maiden Surname)*: SHANA ARMARNICK

19a. Informant's Name/Relationship *(Type, Print)*: HARRIET SCHULMAN / NIECE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2204 SHEFFLIN COURT - BALTIMORE, MD 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BETH TFILOH CONGREGATION

Date: 1/15/01

20c. Location - City or Town, State: WOODLAWN,MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD.21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimers Type Dementia — 2yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] MD

29c. License number: D27034

29d. Date signed *(Month, Day, Year)*: January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira Hunter Copeland MD 1838 Greene Tree Road Pikesville, MD 21208

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature ▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00984

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNIE B. LEE
2. Date of Death (Month, Day, Year): JAN. 12 2001
3. Time of Death: 11:49 PM
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212426963
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12 13 43
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2710 EDMONDSON
10f. Zip Code: 21223
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -8- College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRODUCE MANAGER
16b. Kind of Business/Industry: SAVE RITE

17. Father's Name (First, Middle, Last): HENRY JOHNSON
18. Mother's Name (First, Middle, Maiden Surname): CORA LEE

19a. Informent's Name/Relationship (Type, Print): JOANN LEE(DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2710 EDMONDSON AVE. BALTIMORE, MARYLAND 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK
Date: 1-18-2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Vernon R. Bailey
22. Name and Address of Facility: VERNON R. BAILEY FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CARDIAC ARRHYTHMIA	60 MIN
Due to (or as a consequence of): b.	ACUTE PULMONARY EDEMA	1½ HRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	ACUTE MYOCARDIAL INFARCTION	1½ HRS
Due to (or as a consequence of): d.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Janet V. Moghbeli, MD
29c. License number: D14949
29d. Date signed (Month, Day, Year): 1/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JANET V. MOGHBELI, MD BON SECOURS HOSPITAL, 2000 W. BALTIMORE ST. BALTIMORE MD 21223

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00985

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ERNEST Lewis

2. Date of Death Month / Day / Year: 1 / 11 / 2001

3. Time of Death: 9:47 P.M

4a. Facility Name *(If not institution, give street and number)*: Gilchrest HosPice Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 251-26-6008

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/11/1921

9. Birthplace *(State or Foreign Country)*: SouthCaroline

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 238 South Dallas Ct.

10f. Zip Code: 21231

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Janitoral

16b. Kind of Business/Industry: Chrsyler Plimount

17. Father's Neme *(First, Middle, Last)*: UKN

18. Mother's Name *(First, Middle, Meiden Surname)*: Supie Sheppard

19a. Informent's Neme/Reletionship *(Type, Print)*: Priscilla Fowlkes-Daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1715 N. Central Ave. Baltimore, maryland

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Crametion 3 ☐ Ramoval from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crametory or other piece)*: Loudon Park Cemetery Date: 1/20/01

20c. Location - City or Town, Stete: Baltimore, maryland

21. Signature of Funeral Service Licensee: Geoffrey Miller

22. Name and Address of Facility: Miller's Metropolitan Chapel P.C.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediate Ceuse (Final diseese or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. LUNG CANCER

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

Due to (or es e consequence of):

c. PULMUNARY FIBROSIS

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*:

28b. Time of Injury:

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred:

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*:

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et tha time, dete end place, end due to the ceuse(s) end menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature end title of certifier: Raymond Anzeme

29c. License number: D34184

29d. Dete signed *(Month, Day, Year)*: 1/12/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND A. NZE MD, 7801 York Rd #100, Towson MD 21204

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 17 2001

32. Registrer's Signeture: Jeanne L Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

JANUARY 11, 2001 9:47 P.M

ERNEST Lewis

01-0163-510
LILA B. McGRANT
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00986

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILA B. McGRANT
2. Date of Death (Month, Day, Year): JANUARY 10 2001
3. Time of Death: 12:00 P
4a. Facility Name (If not institution, give street and number): 124 W. FRANKLIN ST. APT# 1104
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 264-26-8587
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB.3,1916
9. Birthplace (State or Foreign Country): ALABAMA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 124 WEST FRANKLIN STREET APT. 1104
10f. Zip Code: 21201
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: DEPARTMENT OF SOCIAL SERVICE

17. Father's Name (First, Middle, Last): WILLIAM FLOYD
18. Mother's Name (First, Middle, Maiden Surname): MINNIE GARY

19a. Informant's Name/Relationship (Type, Print): CYNTHIA HODGES-DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1523 NORTHGATE RD. BALTIMORE, MARYLAND 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): LOUDON PARK CEM. Date: 1/18/2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: LEWIS T GWYNN — Lewis T Gwynn
22. Name end Address of Feciility: LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one causa on each line. (Approximate Interval Between Onsat and Death)

Immediate Causa (Finel disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? INSPECTION 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Chuteno
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JANUARY 11, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Dennis Chuteno 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 00987

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEROME MAPP
2. Date of Death (Month, Day, Year): JANUARY 6 2001
3. Time of Death: 112 AM

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: unk
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 43 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 29, 1957
9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: unk
10b. County: unk
10c. City, Town or Location: unk
10d. Inside City Limits: unk 1 [ ] Yes 2 [ ] No
10e. Street and Number: unk
10f. Zip Code: unk
10g. Citizen of What Country: USA

11. Marital Status: unk — 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: unk
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Johns Hopkins Hospital
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 600 N. Wolfe Street Baltimore, MD 21287

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. polymicrobial sepsis — 5 DAYS

Due to (or as a consequence of):
b. infected hemodialysis catheter — 6 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. medical noncompliance — unknown

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
brain death after ventricular fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Aimee Zaas, MD
29c. License number: RES. 000
29d. Date signed (Month, Day, Year): JANUARY 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AIMEE ZAAS 600 N. WOLFE BALTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

00-172-005
WILLIAM MC FADDEN
JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00988

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William McFadden Jr.
2. Date of Death Month Day Year: JANUARY 10, 2001
3. Time of Death: 12:53 P.M.
4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-64-5776
6. Sex: XX M 2☐ F
7. Age *(In yrs. last birthday)*: 46 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09 02 54
9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 1329 North Carey Street
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter
16b. Kind of Business/Industry: Self Contractor

17. Father's Name *(First, Middle, Last)*: William McFadden Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Kerney

19a. Informant's Name/Relationship *(Type, Print)*: Evangeline Diggs-Fiancee
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1214 Whatcoat Street, Baltimore Md 21217

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion Cemetery
Date: 1/18/01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LOWER GASTROINTESTINAL HEMORRHAGE
Due to (or as a consequence of):
COMPLICATED BY CIRRHOSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature], M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JANUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Amended Item#23a perPHYG792 2/6/2001 EW
amend item 8 per fh G791 1/17/01 yf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00989

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
DORENE	MCINTYRE		JANUARY 11 2001	2:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-48-7872	1☐ M 2☒ F	57 Yrs.			~~01~~ 11 ~~11~~ 8 ~~01~~ 44	N.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Owings Mills	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8371 Township Drive	21117	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	4yrs+	Department Head (Math Dept.) City Schools	

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Andrew Friday	Marjorie Rankin Friday

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117
Jeraline Jones-Truesdale-Sister	8371 Township Drive, Owings Mills, Md

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	King Memorial Park	1/17/01	Randallstown, Md

21. Signature of Funeral Service Licensee: Jerry L. Thompson

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	22 DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ACUTE LYMPHOCYTIC LEUKEMIA	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
RESIDENT	RES - 000	JANUARY 11 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHUAIB LATIF JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET BALTIMORE MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 19a per fh G791 1/17/01 yf

Certificate of Death

Reg. No. 2001 00990

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAMUEL MYERS

2. Date of Death: Month JANUARY Day 10 Year 2001

3. Time of Death: 0650 a.m.

4a. Facility Name (If not institution, give street and number): VETERANS Administration Hospital

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-01-0104

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): DEC. 18, 1915

9. Birthplaca (State or Foraign Country): SOUTH CAROLINA

Usual Rasidance of Decedant

10a. Stata: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No

10e. Street end Number: 833 W. PRATT STREET

10f. Zip Code: 21201

10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Raca - Amarican Indian, Black, Whita, atc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 12TH GRADE. College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): U. S. COAST GUARD

16b. Kind of Business/Industry: COAST GUARD

17. Father's Nama (First, Middla, Last): ARTHUR MILES

18. Mothar's Name (First, Middla, Maiden Surnama): NANCY R. GADSON

19a. Informant's Name/Relationship (Type, Print): ~~LANDRA HILL (NIECE)~~ Lenora M. Hill (niece)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 5523 HUTTON AVENUE, BALTO. MD. 21207

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Nama of cematery, crematory or other placa): GARRISON FOREST

Data: 01-17-01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee:

22. Nama and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart tailure. List only one cause on aach lina.

Approximate Intarval Between Onset and Death

Immediata Causa (Final disease or condition resulting in daath)

a. Renal Failure

Dua to (or as a consequanca of):

b. SEPSIS

Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last

Dua to (or as a consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

Multi-Organ Systems failure,

Brain Tumor - Meningioma

23b. Did tobacco usa contributa to the causas of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Rasidanca 8 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the tima, data and placa, and due to tha cause(s) and mannar stated.

29b. Signature and titla of certifier: M.D.

29c. License number: P13891

29d. Data signed (Month, Day, Year): January 10 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): BENJAMIN LOWENTRITT, MD. 29 S. Greene St. Baltimore, MD 21201

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Benjamin G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Attending Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00991

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Gerald	Mancuso		January 10 2001	3:40 PM

4a. Facility Name (If not Institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St Josephs Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-44-2668	1 [X] M 2 [ ] F	55 Yrs.			June 5, 1945	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Baltimore	Dundalk	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6508 Colgate Ave	21222	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 yrs.	2 yrs.	Welder	Steel

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Mancuso	Laura Bojek

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lisa Koehler Daughter	3537 Honeysuckle Ln. Essex, Md. 21220

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	St. Stanislaus Cem.	Jan 15, 2001	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Occlusion

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Charles F. O'Donnell MD	D-09383	January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. O'Donnell, M.D. 111 Hamlet Hill Rd. #408, Balto. Md. 21210

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	[signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00992

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris M. Neal

2. Date of Death (Month, Day, Year): Jan. 15, 2001

3. Time of Death: 6:15am

4a. Facility Name *(If not institution, give street and number)*: Milford Manor Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-22-2780

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Yaer: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Day, Year)*: 05-12-27

9. Birthplace *(Stata or Foreign Country)*: MD

Usual Rasidence of Decedent

10a. Stata: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 3401 Holmes Avenue

10f. Zip Coda: 21217

10g. Citizen of Whaf Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedenf Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yas, specity Cuben, Maxicen, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Americen Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA

16a. Decedent's Usuel Occupation *(Give kind of work dona during most of working lifa. DO NOT use ratired)*: Day Care Provider

16b. Kind of Businass/Industry: in home

17. Fathar's Nama *(First, Middla, Last)*: George Meade

18. Mothar's Nema *(First, Middle, Maidan Surnama)*: Dorothy Warren

19a. Informent's Name/Ralationship *(Type, Print)*: Bernadine McIver

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 2504 Steele Road Baltimore, Maryland 21209

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Steta 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or othar placa)*: Woodlawn Cemetery

Deta: 01-20-2001

20c. Location - City or Town, Stata: Woodlawn, MD

21. Signafura of Funaral Service Licensee: ▶ Gladys Warren

22. Nama and Addrass of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enfer tha disease, or complicetions that caused tha daath. Do not entar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haert feilura. List only ona causa on each lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final diseasa or condition rasulting in death)

a. Coronary Artery Disease — Approximata Interval: 1 year

Due to (or es e consequance of):

Sequentially list conditions, if any, leading to immediafa causa. Entar Undarlying Ceuse (Diseese or Injury that initiated evants rasulting in death) Last

b.

Due fo (or es a consequance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contributs to the causes of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior fo completion of causa of death? 1☐ Yas 2☐ No

25. Wes casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Deafh *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☒ Nursing Hama 5☐ Residence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☐ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, streaf, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ [signature]

29c. License number: D27034

29d. Data signed *(Month, Day, Year)*: January 17 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Dr Hinkel Copeland MD 1838 Greene Tree Road Pikesville MD 21208

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00993

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick K. Nizer

2. Date of Death: Month 01 Day 14 Year 01

3. Time of Death: 6.00 PM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219 26 1217

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Aug. 12, 1938

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8412 Rugby Road

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: Electrical

17. Father's Name (First, Middle, Last): Frederick L. Nizer

18. Mother's Name (First, Middle, Maiden Surname): Helen C. Kauffman

19a. Informant's Name/Relationship (Type, Print): Richard W. Nizer / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1413 Fairbanks Drive Hanover, Maryland 21076

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.

Date: 1/16/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on aach line.

Approximate Interval Between Onsat and Death

Immediata Causa (Final diseasa or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequenca of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

NON-Q WAVE MYOCARDIAL INFARCTION

DIABETES MELLITUS, CEREBROVASCULAR ACCIDENT (INTRACRANIAL BLEED)

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and dua to the causa(s) and mannar stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D51245

29d. Date signed (Month, Day, Year): JANUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAJID SHARIF NORTH ARUNDEL HOSPITAL - 301 Hospital Drive - GLEN BURNIE MD 21061

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Frederick K. Nizer

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00994

NELSON, JOHN M

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN MELVIN NELSON
2. Date of Death (Month, Day, Year): JANUARY 15, 2001
3. Time of Death: 4:10 AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-10-7748
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 20, 1907
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 21 ARCHWOOD AVENUE
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PLATER
16b. Kind of Business/Industry: AIRCRAFT MANUFACTURING

17. Father's Name (First, Middle, Last): THOMAS S. NELSON
18. Mother's Name (First, Middle, Maiden Surname): NETTIE MYERS

19a. Informant's Name/Relationship (Type, Print): KENNETH E. NELSON (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT. 2 BOX 2963, WATERTANK ROAD, GLENVILLE, PA. 17329

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK
Date: 01/18/2001
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: [signature] MD1220
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CORONARY ARTERY DISEASE
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D51245
29d. Date signed (Month, Day, Year): JANUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAJID SHARIF NORTH ARUNDEL HOSPITAL - hospital Drive. Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00995

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WALTER ORAM

2. Date of Death: Month JANUARY Day 14 Year 2001

3. Time of Death: 6:00 AM

4a. Facility Name (If not institution, give street and number): Keswick Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-10-1675

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 28, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3811 Canterbury Road

10f. Zip Code: 21218

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Comptroller

16b. Kind of Business/Industry: Accounting

17. Father's Name (First, Middle, Last): Charles Safton Oram

18. Mother's Name (First, Middle, Maiden Surname): Carrie Kenny

19a. Informant's Name/Relationship (Type, Print): John D. Butler Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 South Natchez Trail Medford Lakes NJ 08055

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 1/18/01

20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenaker

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 4 YRS

Due to (or as a consequence of):

b. ISCHEMIC / DILATED CARDIOMYOPATHY (EJECT FRACTION < 10%) — 4 YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. CORONARY ARTERY DISEASE — 8 YRS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERMANENT PACEMAKER (1998) SICK SINUS SYNDROME

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 12399

29d. Date signed (Month, Day, Year): JANUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES DONOVAN III, MD KESWICK 700 W. 40TH ST BALTIMORE, MD 21211

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00996

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANTHONY TONY OTTONE
2. Date of Death Month Day Year: January 09, 2001
3. Time of Death: 16:21
4a. Facility Name *(If not institution, give street and number)*: 7149 EASTBROOKE AVENUE
4b. City, Town, or Location of Death: EASTWOOD
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-14-4983
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 12, 1924
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: EASTWOOD
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7149 EASTBROOKE AVENUE
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: '43-'46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LOCOMOTIVE
16b. Kind of Business/Industry: BETHLEHEM STEEL

17. Father's Name *(First, Middle, Last)*: LEONARD OTTONE
18. Mother's Name *(First, Middle, Maiden Surname)*: TILLIE TAMBERINO

19a. Informant's Name/Relationship *(Type, Print)*: PHYLLIS NICHOLSON - DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7149 EASTBROOK AVENUE BALTIMORE, MARYLAND 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OAK LAWN CEMETERY
Date: 1-12-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Elizabeth Selinski
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Severe Anemia
Due to (or as a consequence of):
b. Myelodysplasia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Tony Waterbury, M.D
29c. License number: D09559
29d. Date signed *(Month, Day, Year)*: 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LARRY WATERBURY, MD JHSHC 4940 EASTERN AVE., BALT., MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: ▶ Lenora A Locke

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00997

Madelyn Pirozzi January 16, 2001 @ 10:05AM

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Madelyn D. Pirozzi	January 16, 2001	10:05 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
G.B.M.C. Hospice Gilcrest Ctr.	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-22-3331	1☐ M 2☒ F	84 Yrs.			Feb. 10, 1916	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Edgemere	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7815 North Cove Road	21219	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8 Years		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harvey J. Ingle	Rosalie Humphreys

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Ralph Pirozzi, Jr. (Son)	4908 Willow Lane Myrtle Beach, SC 29575

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Parkwood Cemetery	1/18/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. cholangiocarcinoma	1 month
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A. Anthony Riley, MD	D25205	January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ Serena D Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#3 perPHYG791 1/17/2001 EW

Certificate of Death

Reg. No. 2001 00998

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUDOLPH PFEIFFER
2. Date of Death: Month 1 Day 6 Year 2001
3. Time of Death: 7:49 AM
4e. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEMS
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 194 28 9174
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/14/31
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 381 Dutch Ship Road
10f. Zip Code: 21122
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1950-1974
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): / College (1-4or 5+): 4 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Data Analyst
16b. Kind of Business/Industry: Sentel Research Co.

17. Father's Name (First, Middle, Last): Richard Pfeifer
18. Mother's Name (First, Middle, Maiden Surname): Mina Benz

19a. Informant's Name/Relationship (Type, Print): Katherine Pfeifer / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 381 Dutch Ship Road Pasadena, Maryland 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD State Veteran Cem.
Date: 1/9/01
20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: George Gonce
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPOTENSION
Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ryan McCormack MD
29c. License number: 13112
29d. Date signed (Month, Day, Year): 1/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RYAN McCORMACK MD / 22 S. GREENE ST. / Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 00999

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE S. PLOCIENNIK
2. Date of Death Month: JAN Day: 15 Year: 2001
3. Time of Death: 12:30pm
4a. Facility Name (If not institution, give street and number): STELLA MARIS HOSPICE DULANEY VALLEY
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-14-3515
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year)
9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State: md
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 822 S. Kenwood Ave
10f. Zip Code: 21224
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House wife
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): MARTIN MROZINSKI
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE KALZOROWSKI

19a. Informant's Name/Relationship (Type, Print): PAMELA DAILY (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2021 Brady Dr, Forrest Hill, MD. 21050

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS Cemetery
Date: 1/19/2001
20c. Location - City or Town, State: BALTIMORE MD

21. Signature of Funeral Service Licensee: Anthony C Connolly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk PA 7110 Dollos Pt Rd Dundalk MD 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D45725
29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature:

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

JANUARY 15, 2001 12:40 p.m.

FLORENCE PLOCIENNIK

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01000

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH POTOSKY
2. Date of Death (Month, Day, Year): JAN 15, 2001
3. Time of Death: 8:30 PM
4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 074-30-0646
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-19-1902
9. Birthplace (State or Foreign Country): RUSSIA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6121 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ISRAEL LEVITTAS
16. Mother's Name (First, Middle, Maiden Surname): ITA "UNKNOWN"

19a. Informant's Name/Relationship (Type, Print): MAURICE POTOSKY-SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3505 BERET LANE, SILVER SPRING, MARYLAND 20906

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH DAVID CEMETERY
Date: JAN 17, 2001
20c. Location - City or Town, State: ELMONT NEW YORK

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finel diseese or condition resulting in death): a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last: b. MULTI-INFARCT DEMENTIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D18084
29d. Date signed (Month, Day, Year): JANUARY 16, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): D.D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

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